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## A CASE OF GENERAL PNEUMOCOCCAL INFECTION.

By Donald A. Cameron, M.B., Ch.M. (Syd.),  
Brisbane.

I was asked by Dr. Robertson to see K. St. J., age 7 years and 4 months, at 10 p.m., on October 22, 1914. She lived 4 miles out of town. The little girl was a well nourished child, the picture of health on leaving for school in the morning. About 3 p.m. she felt ill with pains in the lower part of the abdomen, and she was allowed to leave for home, which was about half a mile distant. She could not have gone more than half way, as she was discovered, in great pain, lying under a tree. She vomited several times before I saw her, and had severe abdominal pains, with diarrhoea. The pains were situated in the lower part of the abdomen. She also complained of severe pains in her limbs, and resented interference. Her temperature was 104°, pulse 140, and respirations rapid. There was some general abdominal tenderness. No abnormal physical signs in chest were detected. There was slight redness of the fauces. Her cheeks were flushed, and the skin was dry and burning. The severe and sudden onset of symptoms made me give a provisional diagnosis of pneumonia or scarlet fever. The sudden general tenderness of abdomen, with diarrhoea, in a child was in favour of a pneumococcal infection.

Anticipating that pneumonic signs would develop in the chest, I decided to leave her until the morning. On examination next morning, I came to the conclusion there must have been a perforation, so I removed the child to a private hospital and operated at 10 a.m. I cut down over the appendix, through the right rectus sheath. A large quantity of thin, turbid fluid poured out of the peritoneal cavity. The intestines in lower part of abdomen were very inflamed, as was the appendix. I removed the latter quickly, and hurriedly examined the bowel for swelling or perforation of any of the Peyer's patches. Failing to find a perforation, I closed abdomen, with a drainage tube right down to pelvis. The wound was sewn up with strong, plain catgut for the peritoneum and for the fascia, and silkworm-gut for the skin. The child was kept in the Fowler position. No saline solution was given, as I have discarded it in cases with general peritonitis. I have not seen any benefit from its use, and it annoys the patients, especially children.

A swab and culture-tube showed a pure pneumococcal infection. An initial dose of 1,000,000 pneumococci from a stock vaccine was injected, and later on autogenous vaccine was used. The child had severe pains all over the body since the commencement of her illness, especially in the right shoulder. The pains at times left one part and started in another quite suddenly; the temperature remained high (see Chart) and pulse rapid. She looked very ill. A cough developed on 29th October, and she

was very restless. At midnight on the 31st October, while coughing, the abdominal wound burst open and the intestines were protruded. Under an anæsthetic the wound was resutured with through and through silkworm-gut and kangaroo tendon for the fascia. As there was some dulness at the base of the right lung, advantage was taken of the anæsthesia to insert a large exploring needle, but no pus was found. I failed again two days later. On the evening of 4th November, feeling certain there must be pus, I inserted the large aspirator needle and drew off 3 xiv. of thick pus. This pus contained a pure culture of pneumococci.

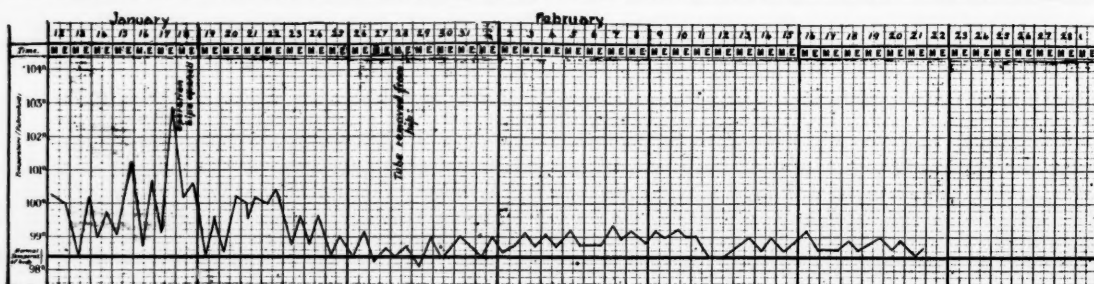
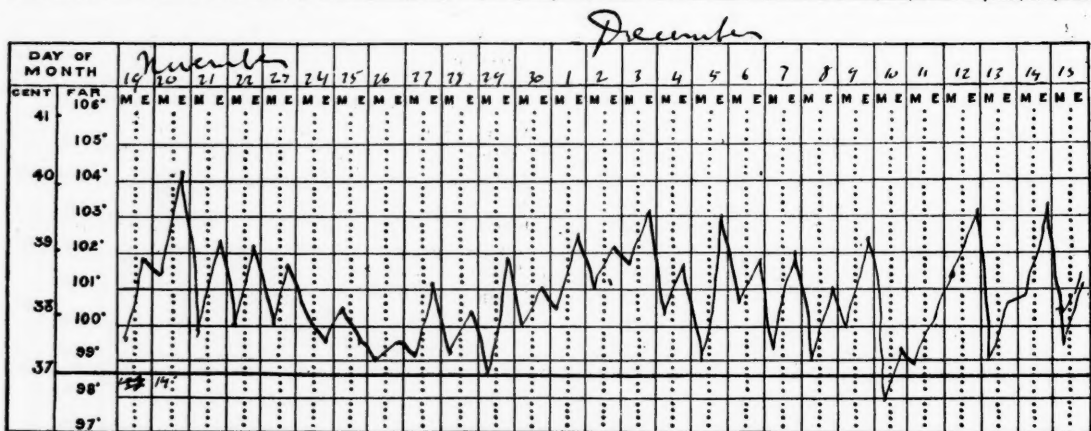
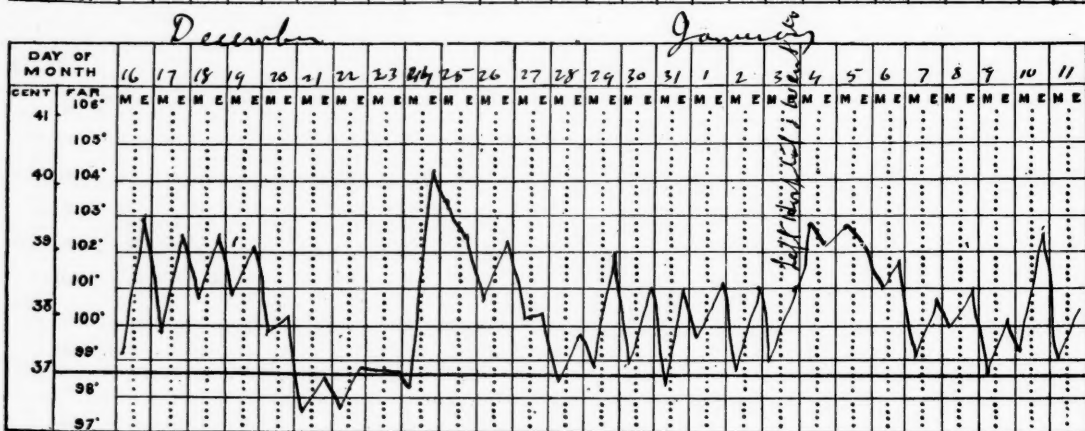
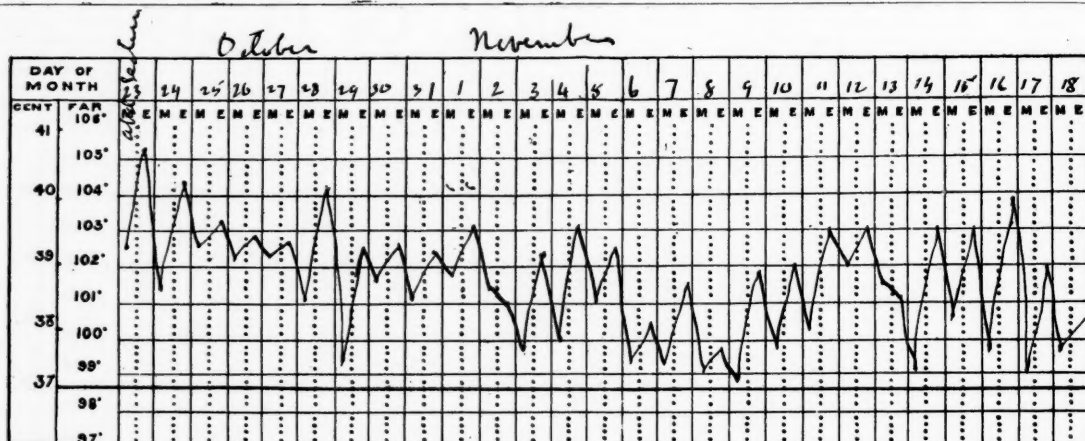
On the 5th November, under chloroform anæsthesia I removed about an inch of a rib low down in right axilla, in the situation where pus was obtained. A large drainage tube was left in cavity. The temperature dropped to 99.4° next morning, but in a few days mounted again steadily, and dulness was perceptible at the left base. I may state that no physical signs of changes in either lung had been detected before the dulness appeared.

On the 13th November I aspirated 3 vi. of thick pus from the left pleural cavity; the temperature again dropped to 99.4°.

On the 16th November, as the dulness was increasing at the left base, and as I considered it was now safe to open both pleural cavities, the child was given chloroform, and I removed portion of a rib in left axilla and inserted a drainage tube. The child was not progressing satisfactorily, so, after a consultation with Dr. Turner and Dr. Robertson, she was given an anæsthetic in the bed on November 21st, and I inserted my finger into the right side of the chest to ascertain if there were any pockets of pus. The tube was re-inserted, having been left out a few days previously. Very little pus was found, however, only plastic lymph.

We now had considerable difficulty in getting the bowels to act satisfactorily, and the temperature remained high. She vomited occasionally, and there was some abdominal distension.

On 24th November she vomited early in the morning, and no action of bowels could be effected, and during the day the vomiting increased. The small intestine became more distended, while the colon appeared empty. Contractions in the small intestine were evident. At 10 p.m., though the child was desperately ill, I decided to open the abdomen for intestinal obstruction. The old incision was opened, and several bands of adhesion were broken down. As the colon did not inflate, I looked for and found a thin band, like a strong string, crossing and constricting the small intestine at the junction with the colon. Immediately I divided the band, flatus passed into the colon. The child vomited only once after the operation. Next day a very large, offensive stool was passed, and her general condition improved steadily.



On the 27th November there was a considerable amount of pus from the chest tubes, but none from the abdomen. The tube in the latter was therefore removed. As the discharge came away in fits and starts from the right side of the chest, I obtained the impression that a cavity had filled up, and had burst through some opening. I was, however, unable to locate the pocket.

From the 28th November she complained bitterly of pain in her right shoulder, though nothing could be found to account for it. The wasting had been progressive, and the child was now exceedingly thin. The left lung was expanding fairly well, far better than the right. There was some difficulty in keeping the bowels open during the ensuing days, and aspirin was given to relieve the pain in the right shoulder.

On the 10th December she vomited several times, and still complained bitterly of pain in the right shoulder. As I felt certain that there must be pus somewhere in right side of chest, she was placed under an anæsthetic on 13th December. No pus was found when the finger was inserted through the old wound, but a very large exploring syringe drew off some when inserted 2 inches from mid line in front in the third interspace. The needle was left *in situ* and part of the lower rib was removed close to the cartilage. A considerable quantity of pus was evacuated from deep down. No evident communication with the old empyæma was found, and it was deemed advisable to waste no time, but to insert tube as quickly as possible, as the child's condition was critical.

By this time she was a mere skeleton. I was pleased to note that a culture taken still showed a pure pneumococcal infection. From this time the child's general condition improved steadily, though there was no gain in weight. On the 20th December the temperature dropped, and remained below 99° for three days—the first time since the commencement of the illness. She still had a troublesome cough, which appeared to be due to some reflex irritation, and she still had pain in the right shoulder.

On the 24th December the temperature shot up to 104.2°, the bowels acted four times and the motions were very offensive. On the following day the stools contained blood and mucus, and vomiting commenced. Her life was in the balance, owing to the gastro-enteric attack, up to the 30th December.

On January 4th, though the temperature was still running up and down, it was decided to remove her to her own home. Her general condition seemed better, in spite of her emaciation, and it was thought that the change of environments might materially assist in restoring her to health.

About the 7th January she complained of pain in her right hip. She woke up screaming with pain several times every night, extension was therefore applied with weight and pulley. On the 14th January there appeared to be an indefinite, diffuse swelling of the right thigh, groin and around the hip.

On the 18th, under an anæsthetic, I cut down on the hip joint above the great trochanter. From the tissues a serous fluid exuded, but very little pus. As the capsule of the joint was not distended, I did

not open it. A drainage tube was inserted down to the joint. A little pus and turbid fluid came away during the following days. On the 25th January the temperature dropped below 99°, and has remained so ever since. On the 28th January the tube was removed from the hip. Two days later the extension was taken off. The child was then eating heartily, and was improving rapidly. On the 10th February she sat up in a chair, and on the 14th she was allowed to stand, with some assistance. She could not support her own weight. Gradually, however, she learned to walk again, and is now putting on weight rapidly, and has been allowed to travel to a health resort to recuperate.

The case is very exceptional, and, in some respects, of importance. In the first place, it appears that the whole illness was a pneumococcal infection, with abscess formation. The history shows with striking clearness the pyæmic nature of this infection. Starting in the neighbourhood of the appendix, a collection of pus formed within the peritoneal cavity. The pain in the right shoulder, and the abscesses in the right pleural cavity, in the left pleura, and around the right hip were evidently secondary infections borne by the blood stream and deposited in vulnerable tissues. The nature of the gastro-intestinal attack was not elicited, but in view of the fact that on each occasion when the pus from the various abscesses was examined, a pure culture of pneumococci was obtained, it is probable that this complication and the bronchial trouble were due to the same organisms or their toxins. I regret that I was unable to collect a specimen of the pus from the thigh and hip, but have little hesitation in assuming that this local invasion was similar in character and etiology to those which preceded it.

In the second place, the fact that no secondary infection occurred after the abscesses were opened may be regarded as fortunate, and to this fact the child may owe her recovery.

It is unusual for an infection lasting for three months and leading to multiple abscess formation to remain free from secondary or symbiotic contamination. Apart from the risk of streptococcal infection, there was grave danger of a secondary tuberculosis. The prophylaxis against these sequelæ consists in the free evacuation of every abscess as soon as pus can be localized, and careful nursing in healthy surroundings.

A word should be devoted to the apparent failure of the vaccine treatment in this case. The conditions were undoubtedly favourable. The infection was a pure pneumococcal one. At first, a stock vaccine was used, but after a short time the child was treated with the strain which was producing the chain of symptoms. A glance at the temperature chart demonstrates quite clearly the failure. It has been shown on numerous occasions that in general infections in which a large quantity of antigen is scattered throughout the organism, the introduction of a fresh supply does not call forth a reactive response and a manufacture of the anti-body. Whether better results would have followed the injection of larger doses is impossible to say, but it would appear



as if but little is to be expected from autogenous vaccines in this class of infection.

I am indebted to Dr. Sidney Page for the bacteriological examinations and autogenous vaccine. Drs. Turner, Mathews and Robertson also rendered valuable assistance in administering the eight anaesthetics, some of which were attended with great risk to the patient.

#### NOTES ON SURGICAL TECHNIQUE.

By Llewellyn Lambert, M.D., M.S. (Melb.),  
Honorary Surgeon, Melbourne Hospital.

##### Appendicectomy.

For many years MacBurney's incision has, with most surgeons, been the incision of election for the operation of appendicectomy. The great advantages claimed for it are:—

First, the ready access it gives to the base of the appendix. Second, the fact that, by it, no muscle fibres are cut across and no nerves divided. Examined by the light of experience, however, these claims are often found to be fallacious.

Granted that in most quiescent cases the appendix is readily removed through this incision, yet if, as is not unusual, it should prove to be of the adherent retro-caecal type, or be fixed toward the pelvic brim, it is by no means easy to enucleate it through the narrow intermuscular space between the iliac crest and a thick rectus. Of course, the working space may be considerably increased by carefully splitting the rectus sheath to the midline, and continuing the cut downward in the *linea alba*, but what only too often happens in a difficult case is that the oblique muscles are divided upward at the outer end of the incision, thus doing away with the great claim that it divides neither muscle nor nerve. But, in my opinion, the greatest objection to this method of approaching the appendix is the fact that it is useless for almost any other purpose, and our diagnostic abilities are, alas! not yet sufficiently developed to make it always certain that we are dealing with an inflamed appendix, especially in a female patient.

Some time ago I was asked to operate on two cases in one day, each diagnosed by a competent observer as appendicitis. The condition in each patient turned out to be a leaking ectopic sac, with rise of temperature, right-sided rigidity, and tenderness. Every surgeon of experience has operated for appendicitis and found the symptoms to be due to salpingitis, cholecystitis, or even leaking duodenal ulcer, for any of which conditions MacBurney's incision is useless. The alternative route advised is that of Battle, who opens the outer part of the rectus sheath by a vertical incision, then draws the rectus muscle inward to the mid-line, and incises the posterior part of the sheath and peritoneum.

Other surgeons split the rectus muscle in its outer third, and this is the procedure usually followed by most workers in exploring the upper abdomen. These incisions must damage the nerve supply to the rectus by dividing some fibres and overstretching others, consequently, these patients afterward have, if not

a ventral hernia, a more or less flaccid condition of the rectus muscle internal to the wound.

For these reasons, for several years past, I have always opened the abdomen by a straight incision over the middle of the rectus sheath, the inner half of the anterior layer of which is then carefully reflected from the muscle until the mid-line is reached. The rectus muscle is retracted bodily outward, and the posterior layer of sheath and peritoneum opened in the same line as the anterior layer. By a short incision between the umbilicus and the iliac spine, the appendix is readily reached, the gall-bladder palpated and any abnormal pelvic conditions dealt with. It can be readily extended upward or downward, as circumstances demand. A similar incision over the upper part of the right rectus muscle gives ample room for dealing with such upper abdominal conditions, as operations on the gall-bladder or bile passages, perforations of the stomach or duodenum, gastro-enterostomy, etc. If sutured by continuous suture to the peritoneum and posterior sheath, silk-worm-gut through skin and sheath, continuous cat-gut suture causing the edges of the anterior sheath to overlap, there is perfect restoration of the abdominal wall, no matter how long the incision may be. By it neither muscle nor nerve is injured, and I hope the time is not far distant when it will be considered as inexcusable to damage abdominal nerves needlessly as to cut the median.

Another great advantage of this method is the very slight tendency there is to the formation of a ventral hernia, even after prolonged drainage of an appendical abscess, or faecal fistula. The rectus muscle, during action, strains towards its fellow, and, as the *linea alba*, the line of insertion of the oblique muscles is quite intact, the whole strength of the abdominal wall is preserved. This is in marked contrast to the end result after drainage through MacBurney's incision, where, almost invariably, there is a ventral hernia with the peritoneum adherent practically to the skin.

Theoretically, it might seem very difficult to reach an outlying inflamed appendix through this incision, but anyone using it for the first time will be agreeably surprised at the ease with which this is accomplished, even in the most muscular man, and it is especially easy if Crile's method of blocking off the abdominal nerves by injecting 0.25% novocain solution along the outer edge of the rectus be adopted before incising the sheath.

##### Varicose Veins.

The usual operation of excision has distinct disadvantages. It takes a long time, the nutrition of the large skin flaps is usually poor, sepsis is prone to occur, and various disturbances of sensation are common from division of cutaneous nerves, or their involvement in ligatures, or scar tissue.

A simpler procedure, that has given me every satisfaction, is a modification of Mayo's vein stripping operation. The main vein, having been isolated just below the saphenous opening, is ligatured and divided. The lower end is then seized in the jaws of a long, thin pair of clamp forceps and twisted subcutaneously as far as possible. By a very short incision each prominent vein is then cut down on in



turn, carefully freed from nerve fibres and divided between two clamp forceps, which are then pushed upward and downward under the skin, being rotated all the while, so as to twist each length of vein thoroughly. The whole operation takes but a short time, the small incisions require only two or three sutures, no ligatures are buried, and the bleeding is negligible. From considerable experience of this method I am satisfied of its utility and its ease of execution.

#### SOME POINTS IN THE PATHOLOGY OF DIPHTHERIA.

By W. J. Denehy, M.D. (Melb.),

Clinical Pathologist to the Alfred Hospital, Melbourne.

The main interest of the following cases lies in the incidence of diphtheria in apparently healthy, muscular men, in the wide-spread distribution of membrane, and in the wonderful resistance of the patients to the infection.

The first case illustrates the fallacy of relying on a negative bacteriological examination. The absence of growth in a tube inoculated from a throat swab does not necessarily prove the total absence of Klebs-Löffler's bacillus in the patient's respiratory tract, but only indicates the inability of the physician to obtain the bacteria from the pharynx. A negative find of this character is especially of small value in cases in which laryngeal involvement or implication of the lower respiratory tract is present. The case further demonstrates the enormous destruction which may result from infections with diphtheria bacilli, and the consequent total loss of structure of the larynx, as evidenced by the absence of vocal cords.

In regard to the mode of death, the first case is a typical instance of right heart failure dependent on broncho-pneumonia, involving practically the whole of both lungs, while the fatal result in the second was due to toxæmic heart failure of diphtheritic origin, no pneumonia having been present.

The histories of the cases, in brief, are as follows:

*Case I.*—P.D., male æt. 24 years, was admitted to the Alfred Hospital on October 16, 1914, suffering from sore throat and aphonia. The symptoms had been present for one or two days. On the following day the patient coughed up a quantity of pus. On the 19th there was severe dyspnoea and some cyanosis. A culture made from the mucus of the fauces (swab) was negative as far as *bacillus diphtheriae* was concerned. Signs of broncho-pneumonia on both sides were detected. No areas of consolidation were found. On the 20th, severe dyspnoea, with cyanosis, was present. There was no retraction of the chest wall. The physical signs in the chest were unaltered, but, in addition, there was marked dullness at the left base. The patient died suddenly at 11.30 p.m.

The temperature had varied between 101° at 10 p.m. to 6 a.m. and 103.8° at 10 a.m. Within the 24 hours preceding death, a fall of 6° was registered.

The pulse rate remained about 100 to within a few hours of death. The respiratory rate was 24 to 28, and only reached 32 on two occasions.

The autopsy revealed the following condition: The patient was a very muscular man. Surgical emphysema of the tissues of the chest was marked, and also on the anterior and posterior mediastinum. No gross mechanical cause for the emphysema was discovered, but the probable origin was an escape of air through the opening of a peritracheal abscess, which burst into the trachea on October 17.

The liver weighed 92 ounces, and was congested; the spleen, and kidneys, were also enlarged and congested. The heart was dilated; the cavities and valves were clear.

The left lung weighed 48 ounces, and the right 32 ounces. There was extensive lobular pneumonia, affecting both lungs. Very little air-containing tissue was found.

A continuous, thick, adherent membrane was found, commencing at the epiglottis with a sharp margin, and extending down through the larynx and trachea into the bronchi. The membrane was traced into the bronchi as far as it was possible to dissect them. It peeled off quite easily, and left an ecchymotic surface. No membrane was present in the mouth or naso-pharynx, and the tonsils and palate were quite free. A small, isolated, thin, ragged piece of membrane was detected at the root of the tongue. There was a thick, muco-purulent discharge in the naso-pharynx. The larynx had lost its structure, and no trace of the vocal cords could be found.

A swabbing of the pharyngeal mucus was taken, but no diphtheria bacilli were grown. On the other hand, pure cultures of Klebs-Löffler's bacillus were obtained from the larynx and bronchi.

In the *Proceedings of the Royal Society of Medicine* (October, 1913), Rolleston reported a similar case, with continuous membrane extending into the bronchi in a child aged five years. I am indebted to Dr. Henry Laurie for the notes of the case and for the permission to report it.

*Case II.*—J.A., male, æt. 42 years, died within a few minutes to admission to the Alfred Hospital. A direct smear from the mucus of the fauces revealed bacilli indistinguishable morphologically from Klebs-Löffler bacilli.

The autopsy was conducted within a few hours of death. Very marked staining was present. The heart was dilated, large and flabby. Its walls were friable, and collapsed on the table. The lungs were crepitant, and no pneumonic changes were present. All the organs were congested.

The naso-pharynx was covered with thin membrane, and blood-stained fluid oozed from the surface. A thin, continuous membrane extended from the epiglottis down the trachea into the bronchi, mainly on the left side. There was marked congestion of the whole respiratory tract.

A pure culture of Klebs-Löffler bacilli was obtained *post-mortem* from the trachea and pharynx.

## Reports of Cases.

### PARALYSIS IN A CHILD.

By G. A. Sampson, M.B.,  
Maleny, Queensland.

The etiology of infantile paralysis is still obscure, although observations during recent years have thrown a considerable amount of light on the mode of entrance of the infecting virus and on the way in which this virus may in some cases be passed on from patient to patient. The manner in which the infection was conveyed to the patient in the following case is so doubtful that it would seem advisable to place the history of the illness on record. This becomes all the more desirable, in view of the possibility of the infection being carried by third persons not affected previously, at the time, or subsequently. Maleny is not in the line of traffic from Brisbane, and the only source from which the infection could have been derived appears to me to have been that some person, who had recently returned from the midsummer vacation in Brisbane, may have carried the infection hither.

H.S., aged 6 years, a schoolboy living at Maleny, in Queensland, was quite well until the afternoon of February 18, 1915, when he was attacked with pains in his head and abdomen. On the morning of the 19th he complained of pains in all the limbs, those in the left leg being worst. At noon he was unable to stand. There was a considerable loss of flesh within the first three days of the illness. The patient took his food well throughout the whole course. There were no twitchings and no vomiting. Profuse perspiration was noticed from the beginning.

On February 21, 1915, he was examined for the first time. The temperature was 101° F., the pulse-rate was 136, and the respiratory-rate 38. The limbs appeared to be natural. He complained of pain in them on being moved, but not on being touched. There was marked paralysis of the leg muscles. The power of extension was present, but very weak. The extensor muscles of the forearms acted feebly, while flexion was lost, but the supinators and pronators were active. The grip was good. The left arm and leg were more affected than the right. Power appears to be quite lost in the upper arms. When lifted, he complained of pains in the back. A pillow placed under his head did not cause discomfort, but when the head was lifted off the pillow, severe pain was produced in the neck, and rigidity of the muscles resulted. The muscles of the face and eyes were not affected.

The right patellar reflex was almost absent, while the left jerk was brisk. The plantar reflex on the right side was only just elicited; that on the left side was brisk and flexor.

There was considerable lividity. The *alae nasi* were working, and the respiration was characterized by an expiratory groan, at a later date, the expiration became gasping, the *pomum Adami* and the head itself moving with each respiratory movement. The thorax was fixed, and did not expand, even with a deep inspiration. This effort caused pain in the belly. The lungs and the fauces were clear of abnormal signs. The patient spoke in whispers, and whined feebly. There was a slight, thin discharge within the nares. The heart beat was diffuse and visible. The dullness reached to  $\frac{1}{4}$  inch outside the nipple line.

The abdomen was much distended and tympanitic. There was no detectable enlargement of the spleen. Neither faeces nor urine had been passed for 24 hours. The foreskin was inflamed and covered with scabs, not unlike impetigo; but there was no phimosis. The bladder was distended and tender. It was necessary to hold the patient up to induce him to micturate. He was held in a warm bath (the use of a catheter would have been better), and some urine was discharged; on repeating the process the bladder was emptied. No further trouble was experienced from this source. On two occasions urine was passed into the bed without warning. The bowels opened in response to aperients.

On February 22 the temperature was 98.4° F. and the pulse-rate 120. During the previous night there was a tendency to delirium. The condition of the limbs was unaltered. The neck appeared to be acutely painful. Laryngeal excursions were extensive with each respiratory effort. The abdominal distension was less marked, and no supra-public dullness was made out.

On February 23 he complained of severe occipital headache, of a tingling sensation in the arms, which he asked to have scratched. He had slept fairly well, but had been slightly delirious. The parents noticed the heart impulse. He was found dead at 6 a.m. No autopsy was allowed.

The diagnosis was obviously infantile paralysis. Death was probably due to respiratory paralysis.

## Reviews.

### NEURASTHENIA.

In his small book on the vicious circles of neurasthenia and their treatment<sup>1</sup>, Dr. J. B. Hurry draws attention to a phase of the symptomatology of neurasthenia, the full significance of which has not, perhaps, been recognized in the past. In a previous work the same author pointed out the important part played by the vicious circle in pathology, and showed how a study of this process contributed to the diagnosis, prognosis, and treatment of disease. In the present volume he first discusses in brief the pathology of neurasthenia, characterizing the two dominant conditions of neurasthenia, as morbid irritability and fatigability of the nervous system, and quotes from Binswanger's and Goldscheider's studies on this subject. He then discusses vicious circles associated with the psychoses, with the vascular, respiratory, digestive and genito-urinary systems, and with the sense organs. A concluding chapter on the breaking of the vicious circle contains some good advice. The treatment of neurasthenia is too often a routine affair of drug therapy, a suggested change of air, sea voyage, etc., which often ends in the patient being only more confirmed in his morbid obsessions and introspection. The author rightly emphasizes the immense importance of treating each patient on individual, and not on general, lines, and psychotherapy is assigned its appropriate place. In speaking of the treatment by rest and nutrition, the author refers to *anorexia nervosa* in women, as if that were a symptom of neurasthenia. Surely *anorexia nervosa* is a distinctly hysterical symptom, and hysteria must not be confounded with neurasthenia. The book is well worth reading.

### INSTITUTE OF RESEARCH IN PATHOLOGY AND MEDICINE.

The trustees of the Walter and Eliza Hall Fund, after providing munificent benefactions in New South Wales, now propose to establish an Institute of Research in Pathology and Medicine, to be housed in the new department of Clinical Pathology in the Melbourne Hospital. The Institute would have an endowment of £2,500 per annum, and would be under the control of a special board, including representatives of the trust, of the hospital, and of the University of Melbourne. The proposal is now under consideration by the bodies interested, and we hope in an early issue to be able to give full details of a project so welcome, so full of promise for the advancement of medical science.

### UNCONSCIOUS HUMOUR.

A correspondent has called our attention to the following sentences in an advertisement which has appeared recently in a medical journal of high standing:—

"I have ordered Blank's Food to two other babies on the strength of my own success, and they are satisfied."

"I may confess to you that till trying it on my own child I had rarely ordered your food, though I had nothing against it, but now I certainly shall." (The italics are ours.)

Difficulty is being experienced in obtaining the services of medical practitioners with special experience for many institutions in the Commonwealth. This is due to the fact that so large a number of the members of the profession have either gone to the front, or are holding themselves in readiness to obey the call to duty. We cannot, however, believe that those remaining at home are incapable of carrying out the work to be done efficiently. The attention of our readers to an advertisement appearing on page xii. of the advertisement portion of this issue, in which applications are invited from practitioners who are willing to undertake the duties of medical officer to the Anti-Tuberculosis Dispensary in Sydney.

<sup>1</sup> The Vicious Circles of Neurasthenia and Their Treatment, by Jamieson B. Hurry, M.A., M.D. (Canab.), author of "Vicious Circles in Disease"; 1915. London: J. & A. Churchill. Cr. 8vo., pp. 99, with illustrations. Price, 9s. 6d.

## The Medical Journal of Australia.

SATURDAY, APRIL 10, 1915.

### Quack Advertisements.

In an interim report on the work of the Department of Public Health of New South Wales, the Honourable F. Flowers, M.L.C., has announced his intention of adopting drastic measures to prevent misleading advertisements of nostrums, which are often harmful, usually quite worthless, and always misleading and dangerous because they prevent sick persons from obtaining proper treatment at a time when treatment is still capable of doing good. In New South Wales, thanks to the policy of an energetic Ministry of Public Health, the quack is being harrassed, and will in all probability find his trade seriously impaired or even effectively crushed. Many of the advertisements can be dealt with under the provisions of the Pure Food Act. A short time ago the Department dealt with a peculiarly crass instance of the advertisement of "an injurious and objectionable nostrum" under this Act. As a rule, some difficulty is experienced in obtaining a conviction when vendors or advertisers are prosecuted, and for this reason, pending the passage of fresh legislation, the best method of attaining the desired end is the issue of a prohibition of the sale or advertisement of the nostrum.

In other States, while the law is approximately the same as in New South Wales, these healthy endeavours to check a dangerous and immoral traffic are wanting. While the ineffectiveness of the law is primarily responsible for the continuation of these practices, the chief difficulty which has to be overcome must be sought in the fact that newspaper proprietors find these quacks a fruitful source of income. We have before us a large number of striking advertisements culled from various daily journals in the Commonwealth. In spite of the proclamation by his Excellency the Governor of New South Wales, prohibiting the advertisement of sale of the "Orange Lily Remedies" of the "Ladies' College of Health" in so far as New South Wales is concerned, an advertisement of this "injurious and objectionable nostrum" still appears in the

*West Australian*. Other advertisements of an equally objectionable nature are to be read in the chief daily journals of each State in the Commonwealth. Vaunted remedies for lost vitality, scarcely veiled advertisements of abortifacients, lying promises of cure of kidney ailments, cancer, deafness, consumption, and many other serious diseases, can all be found without much seeking. Whether proof can be adduced or not, it is perfectly obvious to everyone possessed of any medical knowledge, or in fact of any common sense, that these advertisements are one and all fraudulent, inasmuch as they refer to preparations which cannot and do not cure the ailments for which they are recommended, and which, if themselves harmless, effect considerable harm in delaying a proper diagnosis of the ailment by a competent practitioner, and the institution of suitable treatment. If newspaper proprietors were compelled to exercise a clean censorship over their advertisements (it is obvious that they will not voluntarily sacrifice the income derived from this highly questionable source), the quacks and their wares would be far less numerous, and the damage done to the public far less serious. We trust that other Ministries of Public Health besides that of New South Wales, will open a campaign against these nostrum vendors, and at the same time inflict a corrective blow on the proprietors of daily or periodical journals who allow the charlatan to soil their columns.

### ENTERIC FEVER ON THE EAST-WEST RAILWAY.

According to the *Register* an epidemic of enteric fever of considerable extent is spreading along the East-West railway, and is causing much alarm. As is usual in cases of this kind, the account of the outbreak is limited to the measures for dealing with the patients, and no details are given in regard to the immediate cause of the spread. It is, of course, essential that patients suffering from enteric fever, or for that matter from any serious illness, should find suitable accommodation where adequate treatment and nursing can be afforded. But the main point, from the public aspect of the matter, is prophylaxis, and prophylaxis can only be effected if the manner of the spread is thoroughly investigated and understood. Much is assumed in regard to



enteric fever, and the responsibility for local sanitary cleanliness and for proper safeguards against the perpetuation of the fundamental conditions, under which enteric fever can attack a community, is too lightly accepted. Health authorities will have to face the fact that an outbreak of this disease in the area over which they wield control, is evidence of either incompetence or culpable negligence. Enteric fever can only appear and continue to spread where sanitation is defective, where an insufficient control is exercised over the disposal of excreta, and where isolation of persons suffering from the disease or harbouring the Eberth bacillus without manifesting the signs of typhoid fever, is neglected. If the multitudinous authorities cannot be trusted to carry out this important work safely, the control must be taken out of their hands, and placed with a more responsible body. We have expressed the opinion that the care of the public health will not be wholly satisfactory in the Commonwealth until the control is vested in one supreme health authority, under the Federal Government. Six different health policies in the six States cannot be the right way of dealing with problems which do not vary save to a minor extent.

#### PATHOLOGICAL WORK IN AUCKLAND.

Modern medicine demands the equipment of suitable laboratories for routine diagnostic work, and for research into the causation of disease. Every up-to-date hospital must possess its bacteriological and pathological department, and every hospital staff must include trained specialists in these branches of medicine. The work of investigating material derived from patients suffering from conditions of a doubtful nature demands a full knowledge of bacteriology, biological chemistry, and physiological chemistry. It is comparatively rare to find in one man the qualifications of a bacteriologist and those of a chemist. Apart from this routine work, study into the nature of disease, into its etiology, pathology and prevention demand especial training and skill. The pure pathologist thinks differently from the pure bacteriologist, and, in the majority of cases, these specialties should not be combined. A modern pathological and bacteriological department, therefore, requires a staff consisting of three groups of practitioners, each of whom should be expert in his own branch.

The public in Melbourne has just been placed under a great debt of gratitude by the trustees of the Eliza and Walter Hall Fund on the endowment of a pathological institution in connexion with the University of Melbourne. A scheme is

also under consideration by the Auckland Hospital and Charitable Aid Board for the establishment of a bacteriological and pathological department to be attached to the Auckland Hospital. The head of this department it is proposed should be a Government pathologist and bacteriologist, who should receive a salary of from £600 to £700 a year. The proposals put forward are that the Government and the Board should pay half the cost of maintenance of the laboratories, and the Government should add to its share half the salary of the pathologist. Professor Champdaloup and Dr. T. H. A. Valentine, the Inspector-General of Hospitals, have together worked out the details of the scheme. From the arguments employed at a meeting of the Board held on March 16, 1915, it would appear that the cost of maintenance, together with salaries, would not exceed £1,200 per annum. This sum is small for a well-equipped laboratory, and extremely small for a department with two distinct laboratories. On the other hand, excellent work can be done under comparatively crude conditions. It would be advantageous, however, if the staff of the departments could consist of three scientists, one of whom would be the head of the department, and a small number of assistants. We understand that the scheme has been referred to the Hospital Committee for consideration and report.

#### A CORONER ON INFANT FEEDING.

The Coroner has to investigate the causes of death of human beings of all ages, under all conditions and in every possible connexion. In this task he has to be guided by the evidence of witnesses, and, in his judicial capacity, he is supposed to be capable of differentiating between the credible and the incredible and between the relevant and the irrelevant. A sound physiological and medical training is indispensable for the proper discharge of his duties, and for this reason, every coroner should be a medical man. At the same time, he should be legally trained, and possess the lawyer's acumen in discerning between facts and assumptions. At an inquest held at Coburg on March 25, 1915, the Melbourne Coroner and the chief medical witness appeared to hold different views in regard to the proper manner of feeding infants. The witness, Dr. Brett, testified to the starvation of an apparently healthy infant. He termed the condition "physiological starvation," inasmuch as the infant received a curious collection of foods, including cow's milk, barley water, shank broth, fruit juices, lactogen, Scott's emulsion and some peptonized food preparation. In spite of these articles of diet, or perhaps as a result of them, the child became emaciated and eventually died. The evidence showed that the nurse in charge had done her best for the infant, but that the requisite skill in infant feeding was not exhibited. Under these circumstances, the function of the coroner was easily discharged, since there was no question of any carelessness or gross negligence. The case, however, is of some importance, since, at the present time, the medical profession and the State are combining to reduce infantile mortality.

One of the chief advantages of the Baby Clinic system is the effect it has on the mothers in regard to breast feeding. Scarcely 5% of mothers are incapable of feeding their own babies with excellent results, if properly advised and properly looked after. Skilled physicians and experienced nurses can dispense with "foods" in all cases, and with artificial feeding in the vast majority. Grave exception should therefore be taken to the remark which passed from the Coroner that nature's food had not always proved to be the best. Such a statement may undo the good resulting from the educative efforts of those who understand infant care, and should not be allowed to pass uncontradicted. In the case referred to, Dr. Brett maintained that the doctor who treated the child was the best judge of what should be given. If medical practitioners and nurses carry out their work efficiently, there would be no need for enquiries or opportunities for unwise remarks by coroners.

#### A HOME FOR INCURABLES.

The New South Wales Home for Incurables, at Ryde, near Sydney, as is well known, has for a period of 14 years been ministering for the comforts of those who are suffering from advanced and hopeless disease, and have not the means of obtaining relief from pain, or proper care or nutriment. The Home is intended for those who were once able to support themselves in comfort, but who have become necessitous as a result of some incurable affection. The institution is supported exclusively by voluntary contributions, and receives no support from the Government. Before the war broke out, the Committee recognized the desirability of increasing the accommodation of the home to admit a larger proportion of the applicants. Unfortunately, as is often the case with charitable institutions, it was determined to proceed with the work of building before the means for this purpose had been collected. Plans were prepared and a contract signed rendering the Committee liable for £7,000. The erection of the new building is now in progress, but the wherewithal is wanting. The Committee finds itself some £4,000 in debt, as a result of the small response to the appeal. It is realized that the charitable public has many urgent calls upon it at present in connexion with the patriotic funds and similar obligations. In spite of the fact that the first duty at present must be directed toward the nation's need, it is felt that a deserving institution will not be allowed to languish for lack of funds or to fail on account of financial embarrassment. The Committee is therefore confident that the welfare of its 77 chargees will not be neglected, and that the rich of New South Wales will respond to its appeal. We ask medical practitioners to call the attention of those who are in affluence to this most deserving cause, more especially since the maintenance of the integrity of purely charitable institutions is the best retort to the threat of the absorption by the State of hospitals and similar asylums.

#### INFECTIVE DISEASE IN MELBOURNE.

Trouble has again arisen in connexion with the housing of morbilli patients. The Queen's Memorial

Infectious Diseases Hospital at Fairfield is about to be enlarged by a building at the cost of about £2,000. The plans, as we are informed, have been approved, and the work will be carried out as expeditiously as possible. But in the meantime the lack of accommodation raises almost insuperable difficulties. It would be unwise and unreasonable to criticize the scheme until the plans are available and the details are made known. The one fact communicated up to the present, however, is not very reassuring. A considerable shortage of beds is admittedly existent. The remedy would appear to be a building of reasonable dimensions. This cannot be provided for the sum of a couple of thousand pounds. Melbourne should take care that its needs in regard to the isolation of infective diseases are adequately covered.

#### SHORTAGE OF DOCTORS AT THE FRONT.

The President of the South Australian Branch has received the following cable addressed to the Honourable the Attorney-General, and forwarded by him at the suggestion of His Excellency the Governor of South Australia:—

"Terrible shortage qualified doctors here; could you induce any to cable Imperial Government, offering their services for period of war."

The President of the Branch has issued on the Agenda Paper of the Special Meeting held on April 8, 1915, an appeal to each member, asking them to note the contents of the cable, and to consider carefully whether it is not possible for them to respond to the Empire's urgent call in this hour of need.

It is scarcely necessary for any support to be given to this urgent appeal. Medical men who learn of the shortage of doctors; both at the front and in England, will, we are convinced, come forward as volunteers when this is reasonably practicable.

#### A SEQUEL TO THE STEVENS v. B.M.A. LIBEL ACTION.

In *The Medical Journal of Australia*, October 3, 1914, p. 340, reference was made to the apparent impersonation of Dr. A. H. Bennett, of Adelaide, by a witness in the libel action of Stevens v. British Medical Association, heard in the High Court in London in July, 1914. According to *The Times*, Arthur Alfred Henry Bennett, aged 54, described as a surgeon of no fixed abode, was formally remanded, on February 8, 1915, for committal on the charge of committing perjury in the case referred to. It will be noticed that the description now given differs slightly from that given in the libel suit, when the witness was called "Dr. A. H. Bennett, M.D., C.M., Aberdeen," and not "A. A. H. Bennett." No doubt the trial will bring about a disclosure of the identity of the accused. As we stated last year, the only registered practitioner bearing the name and degrees given is Dr. Bennett, of Adelaide, and the fact of the impersonation has caused our South Australian member considerable annoyance and inconvenience.

Attention is called to an advertisement appearing in this issue for an Officer in Medical Charge at the Royal Military College of Australia. Representations have been made by the New South Wales Branch of the British Medical Association and *The Medical Journal of Australia* to the Defence Department to the effect that the salary offered, viz., £500 per annum, is inadequate in view of the important and onerous work required of the medical officer. It has been suggested that the salary should be £600 per annum, rising to £750.

## Abstracts from Current Medical Literature.

### PATHOLOGY.

#### (109) Typhoid and Paratyphoid Infections.

G. Dreyer, E. W. Ainley Walker and A. G. Gibson (*Lancet*, February 13, 1915) emphasize the extreme importance of classifying all cases returned as enteric fever bacteriologically. They are convinced that it is important to make prophylactic inoculations against other bacteria than *Bacillus typhosus*. After dealing with a differential diagnosis between infections due to *b. typhosus* and *b. paratyphosus* (A) and (B) by means of the agglutination test, they state, on the evidence of their own experience that the bacillus which exhibits the highest agglutination titre is the infective agent of the case under examination. If the case is one in which the agglutination of a second micro-organism is due to the presence of co-agglutinins, the curve of co-agglutination will run parallel to the curve of principal agglutination, but at a lower level. In cases of mixed infection, the curves of agglutination are quite independent, and do not run parallel. No case of enteric fever dealt with at the Base Hospital at Oxford has occurred among anti-typhoid inoculated individuals. Six cases of paratyphoid infection were treated, and in 3 the patients had previously been subjected to anti-typhoid inoculation. The serum of patients never agglutinated *b. paratyphosus* (A) or (B) in a dilution of 1 in 25, save when paratyphoid was present. This held good even when the serum agglutinated *b. typhosus* in high dilution. They conclude that it is of the utmost importance that troops should be protected against paratyphoid, as well as against typhoid, infection. A mixed vaccine can be used, containing the three forms of bacilli in equal quantities. In their opinion, the absence of accurate bacteriological diagnosis must vitiate the statistical records of the value of anti-typhoid inoculation.

#### (110) Experimental Purpura.

J. C. G. Ledingham and S. P. Bedson (*Lancet*, February 13, 1915) have supplemented their preliminary communication on the production of *purpura haemorrhagica* in guinea-pigs. The blood changes in these animals after inoculation with anti-plate serum have been followed out in detail. They describe their technique fully, and proceed to give an account of the experimental data. They find that an early fall in the number of blood platelets occurs regularly with the outbreak of the purpura. This condition has also been produced in rabbits and rats with homologous anti-plate serum. Results similar to those obtained in guinea-pigs were noted in rabbits. In addition to its purpura-producing properties, anti-plate serum possesses considerable lytic powers. The fatal issue in small animals is, to a large extent, due to this fact. On the other hand, death

may occur as a result of extensive hæmorrhage, unaccompanied by hæmoglobinuria or other signs of lysis. Sera obtained by immunization with red cells or leucocytes do not produce purpura. They further found that purpura cannot be produced by inoculating animals with heterologous anti-plate sera.

#### (111) Trypanosoma Brucei.

David Bruce, A. E. Hamerton and D. P. Watson and Lady Bruce give a description of the susceptibility of animals to the Zululand strain of *trypanosoma brucei* (*Journal R.A.M.C.*, October, 1914). Two of six oxen showed trypanosomes in their blood. No disease symptoms were noticed. In goats, the Zululand strain appeared to be less active than the Nyasaland trypanosoma. Monkeys died on an average in 29.2 days. The trypanosomes were always present in their blood, but in no case was oedema of the face or corneal opacity noted. The spleen and liver were enlarged, gelatinous infiltration at the base of the heart and hæmorrhages in the epicardium were found. In dogs, blindness caused by corneal opacity was a prominent symptom, and rats appeared to be greatly affected by the strain. They conclude that the pathogenic action of *t. brucei* (Zululand strain, 1913), on various animals is so similar, not only in regard to the symptoms during life, but also in the post-mortem appearances, and rate of mortality, to that of the trypanosomes causing disease in man in Nyasaland, that it affords another proof that these two trypanosomes are identical.

#### (112) Attenuation of Virus.

It has long been known that the immunization of hogs by the injection of attenuated bacillus supester is not attended by any degree of certainty. Robert Graham and A. L. Brückner (*Journal of Med. Research*, January, 1915) have experimented with the virus contained in cholera blood, with a view of determining the effect of attenuation on the immunizing power. The virus, after heating for 1 hour at 60° C., produces cholera, but does not produce sufficient immunity to protect hogs. The disease may be produced by the inoculation of virus attenuated by heating for one-half hour at 60° C. The temperature to which the liquid blood must be heated to produce a reliable vaccine is variable. The same dose of vaccine, injected into an inoculated animal of the same size under similar conditions, may either kill or protect them, or fail to have any effect. Virus attenuated by heat, and not carbolyzed, may retain the disease-producing properties of the original vaccine for at least 24 days. Attenuated virus is worthless in rendering swine immune to hog cholera.

#### (113) Landau's Test for Syphilis.

In 1913 Landau described a simple test, which he claimed to be specific for syphilis. In a series of 90 cases of undoubted syphilis he found that the Wassermann reaction was positive 49 times, and his iodine test positive 55 times. Later he improved his tech-

nique, and he stated that the iodine test results were 27% higher than those of the Wassermann reaction. J. Bronfenbrenner and J. Rockman have studied the question with great care, and have come to a somewhat different opinion in regard to the value of Landau's test (*Biochemical Bulletin*, Vol. III, Nos. 11 and 12, 1914). In the first place, they experimented with a view of determining the optimum time in which the non-saturated fatty acid contained in the syphilitic serum would combine with iodine. They found that the rate of the reaction varied greatly, but that after 16 hours satisfactory results were obtained. In the next place, they found that serum older than six hours should not be used. The test was carried out as follows:—25 mgrs of pure metallic iodine were emulsified in paraffin oil; 2.5 c.cm. of this emulsion were mixed with 0.2 c.cm. of fresh serum. The test-tube was corked and placed in the dark for 16 hours. At the end of this time 2 drops of starch solution were added. A positive reaction is determined by the development of a dark blue coloration. They found in a series of 150 cases of syphilis and 70 normal controls that the reaction was positive in 65% of the syphilitics, while it was positive to the Wassermann reaction in 66%. On the other hand, it was positive 21 times in the normal controls, when the Wassermann reaction was negative. They point out that this shows that the claim of a more delicate specificity of Landau's test is not well founded, but at the same time they regard the fact of the great frequency in which the serum of syphilitics combines with iodine as compared with the serum of normal persons as striking and worthy of further investigation.

#### (114) Diphtheria Traced to Milk.

Hugh A. MacEwan (*Reports to the L.G.B. on Public Health, etc.*, N.S., No. 94) describes an outbreak of diphtheria traced to milk, which occurred in and around Lambeth, London, in November and December, 1913. There were 119 cases, but only one death. A close investigation into the distribution of the cases seemed clearly to indicate a certain milk supply as being the distributing factor. An examination of those milking the cows showed that three of the milkers had sores on their hands. From two of these virulent diphtheria bacilli were obtained, whilst in the third case the sores had practically healed, probably preventing their recovery. It appears also that some of the cows had had sores on their teats. Milk was taken from some of the cows, but diphtheria bacilli were not detected. The sores on the teats resembled cowpox, and it is possible that a diphtheritic infection was superadded to the sores rather than that the sores on the teats were themselves due to diphtheria. It is suggested that the milkers had become infected from the cows, rather than that they were the immediate means of contaminating the milk. The incidence of the cases of diphtheria indicated that the source of in-



fection was a more or less abiding one, as for instance an infected udder, rather than a more variable factor such as a sore on the finger of a milker.

#### PÆDIATRICS.

##### (115) Measles.

Limiting the period of incubation to the interval which elapses between the time of infection and the appearance of the first definite symptoms, which is always a rise in temperature, Herrman (*Arch. of Pediatrics*, December, 1914) states the incubation period of measles to be never less than seven days or more than fourteen. Koplik's spots appear between the ninth and sixteenth days, the catarrh between the eighth and fourteenth days, and the eruption between the tenth and sixteenth days. He believes that the disease is contagious from the beginning of the catarrhal symptoms to the fall in temperature, which usually corresponds to the time of the completion of the eruption. The blood is probably most infectious from 24 hours before to 24 hours after the eruption appears. The secretions of the nose and mouth are the carriers of the infection. The skin scales play no part. Therefore, an isolation of five days is all that is necessary. About 2% to 3% of all individuals enjoy a real immunity to this disease. Infants under five months are practically immune, the immune bodies being conveyed probably through the placenta. One attack confers immunity, with an occasional rare exception. The early manifestations are: (1) Fever, the first definite symptom; the temperature curve often shows an intermission 24 hours after the initial rise. (2) A decrease of weight, averaging only a few ounces, and commencing after the first five days of incubation. (3) A change in the blood picture. About six days before the eruption appears there is a leucocytosis. Later, during the invasion, a leucopenia occurs, with a distinct diminution in the eosinophile percentage, and relative and absolute diminution in the number of lymphocytes. The blood picture changes with the occurrence of a complication. (4) Enlargement of the lymph nodes, including the epi-trochlears. (5) Oral signs. The greater the blood supply the earlier and more distinct the manifestations. Because of this, Koplik's spots are seen most distinctly on the mucous membrane opposite the erupted molar teeth, where there is a slight pressure hyperæmia. (6) A reddening, swelling and injection of the caruncle at the inner canthus of the eye at the very beginning of the catarrhal stage. Koplik's spots can frequently be seen quite clearly on the reddened surface.

##### (116) The Cutaneous Tuberculin Test in Children.

Maurice Fishberg (*Arch. of Pediatrics*, Jan., 1915) applied the cutaneous tuberculin test to 588 children under fifteen years of age, in whose homes there was no apparent active tuberculosis. He compares his findings with the results of a previous investigation on

children living in the "tuberculous milieu." Before the sixth year of life the numbers infected were 50% to 65%. From seven to fourteen years the proportion of reactors was about the same in both groups—from 75% to 83%. The slight difference between the two could probably be ascribed to the fact that in the earlier review the test was applied two or three times to those who failed to react at first, whereas in the latter series the test was only applied once. The author considers that all available evidence tends to show that these infections during childhood are altogether harmless in the majority of instances. That so many give positive reactions to tuberculin and yet are healthy is sufficient proof that infection with tubercle bacilli alone is not sufficient to cause phthisis, and the large number of healed, latent and quiescent tuberculous lesions proves conclusively that in the majority of persons tuberculosis heals spontaneously. These mild lesions are probably not only innocuous but even beneficial, as they protect the individual from exogenous reinfection with tubercle bacilli. Persons who have not undergone a mild infection during childhood, when infected, are apt to develop hæmatogenic tuberculosis of a rapidly fatal type, e.g., tuberculous meningitis, acute miliary tuberculosis, acute pneumonic phthisis, etc. This is actually the case with infants or people who have not been exposed to infection during childhood, and all others who offer virgin soil to the tubercle bacilli. Chronic phthisis is rather a sign of immunity; only the most vulnerable organ—the lung—is affected, and this organ is only rarely affected in this manner in those who have not been "vaccinated" with tubercle bacilli during childhood. The cutaneous tuberculin test is quite reliable in showing whether a person has been infected with tubercle bacilli or not. It is, however, of little value in the diagnosis of the disease known as tuberculosis in its various manifestations. In large cities and even in small rural communities the majority of the children have been infected with tubercle bacilli before reaching adolescence, though they have not necessarily suffered as a result of this infection.

##### (117) Infection of Middle Ear with Vincent's Organisms.

Adam (*Brit. Jour. of Children's Dis.*, February, 1915) reports four cases of middle ear disease in which Vincent's organisms were found in the discharge. The negative features common to the cases were: Absence of much disturbance to the general health, absence of pyrexia, absence of any history of throat infection, absence of the special organisms in swabs from the throat, absence of special infectivity. In no case was there any history of a similar affection in the same family. The positive features in common were: The constant presence of Vincent's organisms, the frequency of the pneumococcus, as compared with other bacteria, chronicity, stinking and profuse discharge, masses of profuse and read-

ily bleeding granulations in the more pronounced cases, erosion of the external parts of the ear, and slight glandular enlargement. The author considers that this infection of the middle ear is a graft on other affections, resulting from gross neglect. In the four cases reported the infection was local and locally virulent, though amenable to appropriate treatment. The infecting organism was only recognizable in smears and not in cultures, and it was probably due to this fact that the disease has been considered a rarity. The best results in treatment were obtained from painting the eroded surfaces with 5% silver nitrate in the spirit of nitrous ether, cleansing, instillation of tincture of iodine, and especially with instillation of ethyl-violet and brilliant green, each in 0.1% watery solution.

##### (118) A Simple Method of Transfusion.

Zingher (*Arch. of Pediatrics*, December, 1914) in transferring human blood from donor to recipient employs one or two 20 c.cm. or 30 c.cm. all-glass syringes, with short, large calibre steel or platinum iridium needles, and a tourniquet consisting of a small piece of rubber tubing and artery forceps.

The donor's veins are rendered prominent at the bend of the elbow by applying the tourniquet at the middle of the upper arm, care being taken not to obliterate the radial pulse. After skin sterilization, the vein is punctured, and the syringe filled. The tourniquet is then released, and firm pressure applied to the puncture. The blood is immediately injected into the muscle of the recipient, the needle being inserted almost perpendicularly to the skin in adults, but more obliquely in children, on account of the thinness of the muscle. The syringe and needle are then thoroughly washed in sterile normal saline. The total time taken need not exceed sixty seconds, a period well within the normal coagulation time of blood. The procedure is repeated, the other arm of the donor being used. For the third injection the blood should be taken from the arm first used, and the needle should be inserted through the same skin opening. With care, no hæmatoma forms, and five to ten syringefuls can be withdrawn from each vein. A syringe-ful of blood can be injected into each of the following muscles of the patient: (1) deltoid, (2) triceps, (3) supinator longus, (4) outer region of thighs into the vastus externus (two injections), (5) the calves, into the gastrocnemii and soleus, (6) the glutei, (7) pectorals and interscapular muscles, if necessary. The injection is painless. No reaction follows, and absorption is rapid. The muscles will be found supple and of normal size and consistence in twelve to sixteen hours. The method may be employed in cases of: (1) hæmorrhage, (2) hæmophilia, (3) chronic anæmia, (4) severe surgical shock, (5) acute and chronic sepsis, (6) malnutrition of infants, (7) various major operations as a prophylactic, (8) various toxæmias, e.g., scarlet fever. The donors must be free from syphilis and tuberculosis.

## THE HEALTH OF THE AUSTRALIAN TROOPS IN EGYPT.

By J. W. Springthorpe, M.D.  
(Lieut.-Colonel, A.A.M.C., Mena), Melbourne.

We have been greatly surprised to find such an amount and severity of sickness in connexion with our Australian Expeditionary Force of 20,000 men encamped near the Pyramids.

Our No. 2 General Hospital has under treatment in Mena House 160 cases; our tents, which have been pitched a few yards away, hold 540 more; and the No. 2 Stationary Hospital already contains 400 others, and is being asked to take in 100 more. In addition, the number of men who are paraded as sick has reached over 150 in one brigade, and seems to be considerable in the majority of others; and it is stated that the field ambulances are full also.

Such an amount of sickness certainly calls for explanation, and so far we have had neither the time nor the data upon which to formulate a judgement. Personally, however, I have drawn attention to the question.

Provisionally the situation seems as follows: Our troops suffered severely from both influenza and measles from the time they left Australia, and they have never been free from either disease since. At the present time over 100 cases of true measles and German measles are under hospital treatment, the disease being apparently of a mild type. Influenza has proved even more prevalent, and much more serious. At the present time the vast majority of medical cases admitted into hospital give an influenzal history, and show influenzal symptoms. The gastro-intestinal type seems uncommon, but the striking characteristic is the amount and severity of the pneumonia, the larger proportion of which—though by no means the whole—is associated with influenza. Probably over 60 out of 80 cases in the medical wards are suffering from pneumonia. The type is severe, the psychoses uncommonly frequent, the delirium, the throat condition, the pleurisy excessive. I have never seen in my 28 years' hospital experience such a proportion of serious cases. A much smaller number of cases show bronchitis, and a few broncho-pneumonia, whilst asthmatic complications are practically absent. Taken together with the climate, that of a winter sanatorium for the wealthy classes from abroad, I cannot find any sufficient climatic element in the causation, though such a deduction might be untenable if it were found that Cairo and surroundings have had a similar experience during the past few months.

What, then, is the cause? There is evidence that the men have been often working upon a poor breakfast, and a poor luncheon. It is more than probable that many of them have been more or less weakened in their reactive and resisting power by influenzal attacks, and have had to work when practically unfit, because little could be found objectively. It is said also, officially, that the men often come back from Cairo (eight miles away), late in the evening, after some dissipation, and suffer from the cold, which is severe at night, having left their overcoats in camp from laziness and other causes. This may be contributory in some cases, but I have seen a large number in which it was apparently not present. From all sides, however, I have been told of another factor, which, in conjunction with the influenza, seems to me to have been in all probability the main exciting cause. It is that the men have been fatigued by too severe exercise. The amount of marching that they have had to do, the weights which they have had to carry, the extra fatigue from the sand through which they have had to trudge, the continuity of the drill, the sweating, followed by exposure, these would certainly produce the vulnerability, general and pneumo-gastric, upon which the pneumonia as I have seen it could fairly be based. The authorities have evidently found some such causation probable, for general orders have just been issued, granting one full day a week holiday. Nothing to be done on Sunday after Church Parade, and only eight hours a day for each of the other five days in the week. Some blame the dust. Certainly the bronchial tubes must often have been coated with dust. One only has to see a brigade returning in a cloud of dust, or to see how, on dusty days, it penetrates everywhere, to understand that.

But the dust seems to be specially non-irritant, and there has been, as already said, a notable absence of bronchitis and asthma.

The measles outbreak requires little explanation. The German measles can be ignored; the true measles have been mild, and so far as I know bronchial complications have been infrequent—another argument against the climatic factor in reference to the spread of pneumonia.

The venereal cases occupy a special position. The quantity is certainly striking, and the proportion of severe cases high. It seems impossible to prevent, nature is too strong, and a certain proportion will always occur. I leave it to more experienced officers than myself to make explanations and suggestions. A contributory factor, according to some, is the easy nature of the Australian, which leads him to be less suspicious, a trifle more careless, and more open to companionship than, say the Territorials, who are also in Egypt. Certainly it is said that there is much less sickness, general as well as venereal, amongst the Territorials than amongst our own troops. Latterly the authorities have tried punitive measures in the shape of isolation, armed guards, cutting off tobacco and visits, and cessation of pay. One detachment claims to have kept the disease at bay by adopting French preventive means. These two extras show some of the, perhaps unnoticed, ramifications.

As regards the general disease I personally felt the situation to be so serious that, had not the general order come for less arduous drill come when it did, I had intended, as senior physician, reporting that an investigation seemed desirable. If the relaxation fails it will be imperative to ascertain the cause.

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## British Medical Association News.

## SCIENTIFIC.

A Clinical Meeting of the Victorian Branch was held at the Alfred Hospital, Prahran, on March 17, 1915, Dr. Honman (the President) in the chair.

Dr. A. V. M. Anderson showed a man with *spleno-myelogenous leukaemia*, who had been under treatment with benzol in doses of 15 minims three times daily. The white cells had diminished in number from 890,000 to 330,000, and the patient was subjectively improved.

A second case shown by Dr. Anderson was that of a man, aged 45, who had been under treatment since July, 1914, for *aneurysm of the aorta*. There had been a systolic murmur heard over the aortic area, dulness over and to the right of the manubrium and the inner end of the right clavicle was raised with each heart-beat. Tracheal tugging was present. The patient's serum yielded a positive reaction to Wassermann's test. X-ray examination showed a definite, pulsating shadow, connected with aorta near the junction of the transverse and ascending parts of the arch. He had been kept in bed for three months, put on a modified Tuffnell's diet and given drachm doses of sodium iodide three times a day. Almost all his signs and symptoms had disappeared.

A third case was that of a man who had been sent to hospital with the diagnosis of disseminated sclerosis. There was weakness of the right leg muscles; Babinski's phenomenon was present, as was some patchy anaesthesia on the same side. There was slight motor weakness in the left leg, and Babinski's reflex was doubtful. No sensory changes were found on the left side. There was a history of syphilis, and the cerebro-spinal fluid gave a positive globulin reaction, and showed lymphocytosis. There was neither nystagmus nor intention tremor, and the case was regarded as one of *diffuse parenchymatous syphilitic disease of the lower part of the spinal cord*. Considerable improvement had followed on the administration of salvarsan and iodide of potassium, with mercury.

Dr. Anderson's fourth case was that of a girl, aged 17, who had suffered from *pericarditis and left pleurisy*, seven months previously. There had been severe cough, a little haemoptysis but very little expectoration. No tubercle bacilli had been found in the sputum, but *pneumococci* and *staphylococci* were present. The temperature had frequently been up to 101°. A lump had developed over one of the

right lower ribs; this was opened and in the pus some lepto-thrix had been found. The abscess was connected with the rib. Other abscesses had been opened in the left arm and near the xyphoid appendix, and there were swellings over the trachea and in the right thigh. The heart was somewhat displaced to the right. Dulness, with weak breath sounds at the base of the right lung, was discovered. Patient was taking sodium iodide and was improving.

#### Pathological Specimens.

Dr. W. J. Denehy exhibited the following specimens:—  
1. Kidneys and adrenals, showing hæmorrhages and marked enlargement of adrenals by effused blood, from a case of *purpura hæmorrhagica*, in which were found blood-stained effusion into the pericardium, and hæmorrhages into lungs and into the omentum.

2. *Melanotic sarcoma* of the tip of the sacrum, with secondary deposits in the lungs, spleen and liver, from a patient aged 56 years. Microscopical sections were exhibited.

3. *Meckel's diverticulum*, 2½ inches long, found in a routine autopsy.

4. A comparison between two specimens—

(a) *Aortic stenosis, with rigid calcified valves*, and

(b) *Ulcerative endocarditis*, affecting the aortic valve.

5. *Hydatid of the kidney* found as an incident in a post-mortem on the body of a person who died of diabetic coma. There were no symptoms nor signs of hydatid ante-mortem.

6. *Ovarian cyst* (intact), weight 29 lbs 5 ozs., removed by Mr. Buchanan. The patient was now in good health.

7. Dr. Anderson's case, B.S., æt. 38. *Blood-borne hydatid tumours*. The primary cyst was found on the posterior surface of the heart as a pale, fluctuating area occupying the interventricular septum and adjoining ventricular muscle. A valvular opening plugged with fibrin was found, and could be seen under the septal cusp of the mitral valve. On inserting a probe, clear fluid escaped and a daughter cyst was found plugging the orifice. The left lung contained subpleural calcified masses about half an inch in diameter. Some of the masses were umbilicated. Dr. Denehy considered that it was probably a case of old calcified tubercular nodules or calcified hydatids. There was one small hydatid in each kidney. The spleen contained two small hydatid cysts at the lower pole. In the right occipital lobe of the brain a large hydatid cyst, with many daughter cysts, was found. The left middle cerebral artery contained a small cyst completely blocking all its branches. A large area of softening and a thin-walled cavity was present, occupying area of distribution of the vessel. The right middle cerebral artery contained a small cyst immediately proximal to its branches, completely blocking the artery. Cerebral softening was present in area of distribution. The lodgement of this hydatid embolus was the immediate cause of death. The remainder of the brain, liver and bones was clear.

Mr. R. Hamilton Russell showed a remarkably characteristic example of *osteitis deformans*. He remarked that there was a tendency to a somewhat loose usage of the term and to its application in almost any case in which there was a curvature of the bones of obscure pathology. The patient was a country man—a market gardener. He was 42 years of age, but looked 10 or 15 years older. He first noticed commencing curvature of the femora some eight years before; he had diminished in stature to the extent of four inches since that time. He noticed that his head was gradually enlarging, so that he had to wear hats several sizes larger than those he had been accustomed to. The head was very large and square looking; the bones of the face were unaltered. The head seemed to have sunk down into the upper aperture of the thorax; the upper dorsal spine was curved and rigid; the thorax was rigid and presented the appearance associated with kyphosis. The clavicles were involved, being enormously thickened, with exaggerated curves. The bones of the arm were apparently free from involvement. Both femora were markedly enlarged and curved, as were the bones of both legs below the knee. On the other hand, the pelvic bones appeared to be normal. The upper extremities of the femora were unaffected, as shown by the normal position of the trochanter on either side in relation to Nélaton's line. Some three months previously he had had an accident to the right leg by being run over by a dray; the knee was injured, and

a very marked enlargement of the upper end of the tibia resulted. This was seen in the skiagram to be due to the development of a sarcoma in the bone. There was little, if any, evidence of arterio-sclerosis; the blood pressure was 150 mm. Hg. The urine was normal.

Dr. Henry Laurie showed two patients—

1. *Spleno-medullary leucæmia treated with benzol*.—Mrs. D., aged 34. The illness began at end of 1910 with diarrhoea, vomiting and weakness. She then noticed a lump in the left side. She was in the Melbourne Hospital in March and June, 1912, and was treated by X-rays with considerable improvement. She was admitted to Alfred Hospital on August 30, 1913. She was very weak, and suffered from continuous vomiting, oedema of the legs and a dilated right ventricle. Examination of blood: erythrocytes, 2,610,000; leucocytes, 742,000; hæmoglobin, 50%; colour index, 0.9; anisocytosis, polychromatophilia, a few normoblasts, many myelocytes. She was treated after the first fortnight with arsenic and X-rays, but no improvement followed. Benzol, in doses of 5 minims, administered in emulsion with olive oil, was given on September 15, 1913. The dose was rapidly increased to ten minims, and later to fifteen. On September 24 the blood count was: erythrocytes, 3,140,000; leucocytes, 31,400; hæmoglobin, 80%; colour index, 1.2. She was discharged on October 8. She was readmitted on November 8, 1914. The spleen then extended beyond the middle line, and the lower edge dipped into pelvis. Erythrocytes, 2,900,000; leucocytes, 218,000; hæmoglobin, 60%; colour index, 1.03. She was put on benzol as before, in doses of fifteen minims, three times a day. The leucocytes dropped to 130,000 on December 7, 1914. On December 24 they numbered 36,000, and on January 28, 1915, the count showed only 9,000. She was discharged on January 29 in very good condition, with the spleen markedly decreased in size. The patient was able to perform the usual household duties without fatigue, and felt well. She was putting on weight.

2. *Tumour of spinal cord*.—Operation. Recovery. This case was reported by Dr. C. Morlet, and published in full in the *Australian Medical Journal* of January 31, 1914. The patient was able to get about freely, and complained only of some numbness in the toes of the left foot.

Dr. R. C. Brown showed a case of *clonic spasms of muscles of mastication*. The patient was 69 years of age. The illness began 18 months before, when "the lower teeth began to hit against the top at bed-time." The spasm gradually became worse, and he had to discard his artificial teeth, owing to injury to the upper gums. He would wake in the morning feeling quite well, but as the day wore on the contractions increased in frequency till the evening, when speaking became difficult, owing to the mouth continually shutting. For the same reason he could drink fluids only with difficulty. He had improved during the past week on bromide treatment. About 15 months previously he had an attack of right hemiplegia, without loss of consciousness, but could not recollect whether the jaw affection preceded this or not. On examination, both sets of masseters and temporals were found to be involved in the spasms.

Dr. Brown also gave a cystoscopic demonstration of a case of *calculous pyonephrosis associated with pregnancy*. The patient, who was 28 years of age, complained of pains "on and off" in the right loin for 18 months, with intervals of comparative freedom. The pain was worse in the recumbent position. No increased frequency of micturition nor pains in the bladder region were present. The pains had become more severe. She was in the third month of pregnancy. On examination, an enlarged, tender, freely moveable right kidney bulging into the loin and descending freely below the ribs was detected. The urine contained numerous pus cells, colon bacilli and large renal cells. In the skiagram a shadow of large calculi was seen in the renal area. The cystoscopic examination showed normal ureteric orifices without any cystitis. From the right ureter creamy pus was ejected at intervals with considerable force.

Dr. W. Spalding Laurie showed (1) a Mongol—typical in some respects, but lacking certain of the characteristics of *Mongolism*. She was a first child, and her age was two years and ten months. She could not walk, talk, nor even sit up. The history was that when nearly twelve months old she was taken to the Children's Hospital on account of backwardness and twitching of the eyes, i.e., nystagmus. She



was constantly rolling and banging her head about; she was regular and clean in her habits, and ate well. Her cry was a peculiar whine, characteristic, he thought, of this condition. The shape of the head, the eyes with well-marked epicanthic fold, and the constant lateral nystagmus were typical. The tongue was well formed, neither large nor round, nor fissured. There was marked muscular flaccidity, occasionally alternating with a spastic condition of the limbs. The flaccidity is said to be constant in the Mongolian type of cretinism. The ears were well formed. The little fingers were markedly incurved. There was a congenital cardiac lesion. A brother, aged nearly two, was backward in teething, walking and talking, but showed no signs of Mongolism. The points emphasized were: (1) The patient was a first born. (2) A younger member of the family was backward without being a Mongol. The patient was not therefore, an "exhaustion product." Of the last three cases seen by Dr. Laurie, two were first-born and one a second child, the elder sister showing pronounced signs of hypothyroidism.

Dr. Laurie also showed (2) a case of early *general paralysis of the insane*. The primary infection occurred only four years before he came under his observation in June, 1914. After infection, he was under mercurial treatment for four months. In May, 1914, he got what he called a "shock." It began with pins and needles in his legs, which travelled up his body and took his speech away. He had a second attack fourteen days later. He was then unable to lift his feet or bend his knees. These attacks lasted for about two hours. Previously, he had some difficulty in retaining his urine. There were no headaches, no vomiting, no pains. When he came under observation, it was noted that there was tremor of lips and tongue, and thickness of speech. His pupils were equal and active. The tongue was protruded in the middle line. All the tendon jerks were increased, and there was slight ankle clonus. Babinski's reflex was negative, and Romberg's sign absent. On September 5 his speech was much worse. Ankle clonus and an indefinite Babinski reflex were noted, more marked on the right side. He has been indoors with a view to intrathecal injection, which, however, was not carried out. The Wassermann reaction was weakly positive. While in the ward, he had an apoplectic attack, confined entirely to the right side. Fibrillary tremor extended to the whole of the left side of the face. It was noted that, during the three months prior to March, he had had two attacks of apparently causeless vomiting. Babinski's reflex had become typical, and pronounced ankle clonus had developed. This case was best classified as a spinal type of general paralysis of the insane. There were no mental or pupillary signs, and no disturbance of sensibility. He had had a single apoplectic attack. It was unusual to see general paralysis develop as early as four years after the primary infection. Bramwell noted 14% of his cases occurring within the first five years. One patient first showed signs 2½ years after the primary infection, and died within 3½ years. In another patient, the paralysis developed four years after the infection. He also reported a case of tabes occurring one year after infection.

Dr. Fay Maclure showed a case of *vesical papilloma*, in a female, aged 53 years. Six months before she had a sudden attack of hæmaturia. She stated that she had previously been quite well, that she passed pure blood, and that she suffered neither pain, nor frequency of micturition nor other urinary symptoms. The bleeding lasted a few hours, and had not been noticed since. With the cystoscope a small pedunculated villous papilloma was seen in the usual position, immediately above the ureteric orifice. An operation for the excision of the tumour was advised, but the patient refused this. Since that time Dr. Maclure had treated a similar condition successfully by means of high frequency current applied by electrode directly to the tumour—the papilloma in this case being completely destroyed by two such applications. He had advised the patient to undergo this comparatively simple method of treatment.

Dr. J. Kennedy showed a case of *Volkman's ischaemic paralysis*. The patient was 14 years. Seven years before he had fractured both bones of the left forearm. Subsequently, ischaemic paralysis set in, with great wasting of the muscles of the forearm, and with contraction and

rigidity of wrist, hand and fingers. This condition was untreated until ten months before, when treatment was commenced according to the method advocated by Robert Jones, of gradual extension by splinting, massage and active and passive movements. This had resulted in a very considerable improvement, so that the patient had become able to extend the fingers and hand fully, and had acquired the power of abducting and adducting all of the fingers.

Dr. S. A. Ewing showed a *laryngo-fissure* for a growth in larynx. The patient was a man, aged 48. He was much emaciated. He stated that he had great difficulty in swallowing for one month, only being able to take fluids with difficulty. There was a history of diabetes and albuminuria; the former had cleared up recently. On examination, a large growth, with a nodular surface, with some hæmorrhagic inclusions could be seen filling the hypopharynx; no view of the larynx was obtainable. The advisability of performing a preliminary gastrotomy to improve nutrition was negated by the presence of occasional dyspnoea and laryngo-fissure was decided upon. A low tracheotomy was performed under 1% novocain infiltration, and then general anaesthesia with chloroform and ether was induced. After the opening of the larynx, 10% cocaine solution was applied to the interior and over the growth. This was found useful in subduing laryngeal reflexes and lessening the amount of anaesthetic administered, and also in keeping the interior of the larynx practically bloodless. The growth could easily be defined, owing to its size, which was about that of a billiard-ball. It was necessary to remove it piecemeal. A nasal snare was found useful in accomplishing this. The growth was attached to the aryteno-epiglottidean fold and the epiglottis. The epiglottis and structures surrounding the origin of the growth were removed with a curved pair of scissors. An ordinary tracheotomy tube was left in during the night, and removed on the following morning. Sips of milk and water were taken the same night, and there was no difficulty in swallowing fluids. Recovery was rapid and uneventful. An ordinary tracheotomy tube was used in preference to Hahn's canula, as being less likely to injure the trachea. By means of gauze inserted into the upper portion of the trachea, there was no risk of leakage of blood.

A meeting of the Eye and Ear Section of the Victorian Branch was held at the Victorian Eye and Ear Hospital on March 23, 1915, Dr. S. A. Ewing (the President) in the chair.

#### Demonstration of Cases.

Dr. S. A. Ewing showed a patient, aged 33 years, who was suffering from *tubercular disease of the larynx*. The patient was first seen in March, 1910, when both vocal cords and the right ventricular region were infiltrated. There was extreme huskiness of the voice and dryness of the throat. He was treated with a saline nasal douche, a formaldehyde spray for the throat and open-air for the general condition. Fifteen months later, the vocal cords were practically normal, save for some hyperæmia, and the voice had regained its natural quality. Some infiltration of the ventricular region persisted. The patient followed his occupation of cab-driver in a country town. In March, 1915, he was again examined, when it was found that two small ulcers were present. The one was situated on the right vocal cord, and the other on the epiglottis. There was also infiltration of the right ventricular region. He had suffered from attacks of dyspnoea for two months. Dr. Ewing considered that the persistence of the infiltration was due to some interference with the recurrent laryngeal nerve, caused by glandular or pleural pressure. The prognosis was unfavourable, on account of the lowered nutrition dependent on the defective air-intake. The case, however, showed that under favourable conditions considerable headway could be made in some cases of well-marked tubercular disease of the larynx.

#### Discussion.

Dr. H. B. Thomson expressed the opinion that the case was unusual, and suggested that there had been a subsidence, and then a fresh outburst. Had the condition been continuously active, he would have expected more loss of tissue. The living conditions of the patient were in favour of partial recovery.

Dr. Percy Webster showed a case of *phlebitis of one retinal vein*.

Dr. R. L. Rosenfield presented three patients for demonstration. The first patient was a man, aged 21 years, who consulted him on October 1, 1914, on account of diminished vision in the right eye of a few days' duration. The vision was:—

$$R. = \frac{1\frac{1}{2}}{60} \quad L. = \frac{6}{6}$$

A gross hæmorrhage in the right eye was seen on ophthalmoscopic examination. Numerous flame-like, small hæmorrhages were seen in the left eye, along the upper retinal veins, and also white patches of exudate, apparently breaking the continuity of the vessels. The left macular region was free, and consequently the central vision was not interfered with. In spite of various forms of treatment employed at the suggestion of other ophthalmologists who were consulted, the hæmorrhagic masses in the right eye organized into fibrous vascular structures of a size and variety of structure rarely met with. The hæmorrhages in the left eye recurred several times, cutting off a large part of the field, and diminishing central vision until the patient was scarcely able to get about unassisted. The hæmorrhagic masses in the left eye underwent fibrotic changes, similar to but less pronounced than in the right eye. The condition was described as *hæmorrhagic retinitis resulting in retinitis proliferans*.

Dr. Rosenfield's second case was one of *detachment of the retina with hæmorrhage*. The patient was first seen on March 1, 1915. He stated that a week previously his right eye had been grazed accidentally with a piece of waste; he had been unable to see with the eye since. On examination, the vision was:—

$$R. = \text{shadows.} \quad L. = \frac{6}{6} \text{ nearly.}$$

The ophthalmoscopic inspection revealed that the retina had been detached all round. The appearance was like that of the interior of a cone, with a white spot at the apex, apparently representing the disc obscured by effusion. There was no gray appearance, as is usual in detachment of the retina, but a general darkened reflex was seen, associated with localized foci of hæmorrhage on the surface. The treatment consisted in rest, with iodide of potassium and tannate of mercury. The vision improved, and had become

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— The retina appeared to have become replaced, although 36 some hæmorrhagic masses on the surface had become organized, and a condition of retinitis proliferans had been produced.

Dr. Rosenfield also showed a case of *diplopia*. The patient had been demonstrated to the Section twelve months before. The chief point of interest in the case was the fact that diplopia always occurred when the patient looked down or to the right. At times, the images were crossed, and at other times the diplopia was homonymous. The right superior oblique was regarded as the offending muscle. In spite of the great variability, the affection had proved to be persistent, and interfered with the patient's work. The speaker had given him a prism—4° axis oblique—and with this assistance, he had been able to perform his work without discomfort. The diplopia was still marked when the patient made extreme movements downwards and to the right. He was apparently quite healthy, and in good condition.

#### Discussion.

Dr. Webster pointed out that the second case was probably one of retinitis proliferans in an early stage. He described definite vessels and extensive hæmorrhages which he had noted in the extreme periphery.

Dr. H. Riddell Stanley showed a case of *central retinitis*.

Dr. Leonard Mitchell showed a boy, aged 16 years, who had fallen, nine months previously, and struck his head on a window-sill. On the following morning the sight of the right eye was misty. The sight of the left had never been good, but since the accident, that of the left eye was worse than that of the right, which appeared to be good. The family history was not quite free from suspicion. Both his father and father's mother had had defective

sight. The patient was the eldest of five children living. His mother had lost one child at the age of 16 months from "teething," and one aged 3 years and 11 months of dropsy (this child had not had scarlatina). She had had two miscarriages. The right eye: No fundus reflex was present. There was apparently a detachment of the lower half of the retina. He could count fingers below at two feet. The left eye: Peripheral choroiditis was seen on the temporal side. There was a myopic crescent and a small coloboma. The refraction worked out at 9 D with 1 D astigmatism.

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matism. Vision was improved to —. Eight weeks later a 60

mass was seen in the anterior part of the right fundus. It was definitely fluffy in outline, but transparent. The diagnosis lay between absorbing hæmorrhage into the vitreous of a tumour of the retina. Transillumination proved negative. The Wassermann test was also negative. Six months later, the left eye was unchanged. In the right eye an extensive mass was seen in the lower half of the vitreous, presenting long streaks of tissue, very suggestive of *retinitis proliferans*. There were many small hæmorrhages in the lower and outer segments. The mass was best seen with + 6.

#### Discussion.

Dr. Webster thought that this case was also one of retinitis proliferans in a very early stage. Dr. Stanley was inclined to this view. He held that the hæmorrhages over the mass favoured this diagnosis.

#### ANNUAL MEETING.

The Annual Meeting of the Western Australian Branch was held at the Perth Public Hospital on Wednesday, March 17, 1915, Dr. Lotz (the President) in the chair.

A letter was read from the Queensland Branch on the subject of the proposed Daylight Saving Bill, and further consideration was postponed until next month.

The Hon. Secretary's report, the Council's report, and the Hon. Treasurer's report for the year were read and adopted.

The result of the ballot for office-bearers for the ensuing twelve months was as follows:—

*President:* Dr. Teague.

*Vice-President:* Dr. Merryweather.

*Hon. Treasurer:* Dr. Trethowan.

*Hon. Secretary:* Dr. Woods.

*Members of Council:* Drs. Clement, Hadley, and Officer.

*Members of Ethical Committee:* Drs. Merryweather, Hadley, and Clement.

*Hon. Auditors:* Drs. Ambrose and Randall.

Votes of thanks were carried to Dr. Lotz, Dr. Trethowan, and Dr. Woods for their services during the past year.

Dr. Trethowan then moved, and Dr. Clements seconded, that the time has now come to appoint a paid Assistant Secretary, at an honorarium not exceeding 50 guineas. The motion was carried unanimously.

Dr. Lotz moved an addendum, which was seconded by Dr. Officer, that the paid Assistant Secretary be appointed by the Council, and that the amount of the honorarium be settled by them. The addendum was carried unanimously.

Dr. Lotz read a very interesting paper on some abdominal cases, in which mistaken diagnosis means death.

#### Report of the Council and Ethical Committee for the Year 1914-1915.

During the year, the Council met seven times, and the Ethical Committee twice.

The average attendance at the Council Meetings was more than five, out of a membership of eight. One member was repeatedly prevented from attending, owing to ill-health.

A considerable amount of work was done in connexion with contract practice throughout the State, and a number of agreements were brought up to our standard. It has, unfortunately, been found impossible to make a standard uniform agreement for State-assisted hospitals, owing to the unwillingness of members concerned to collaborate in drawing it up.

So far as the Council is aware, members practising in Cottesloe, Claremont, and Fremantle, have not yet adopted the model Lodge Agreement for towns.

No success has attended our efforts to get up local meetings throughout the State, or to form local subdivisions. The Council feels that great good would result from such meetings, if only members could be persuaded to arrange them.

It is desired to draw the attention of members to the new issue of the British Pharmacopoeia, in which there are some important alterations.

The Ethical Committee met twice, and dealt with a dispute between two partners.

In conclusion, the thanks of the Branch are due to Dr. Lotz for the diligent and courteous manner in which he has conducted the arduous duties of his office as President.

#### Report of the Hon. Secretary for the year 1914-1915.

During the twelve months, eight General Meetings were held, with an average attendance of over sixteen members.

The following members very kindly read papers: Drs. Moule, Teague, Paget, Landon, Couche, Paton, and Hadley. Numerous other members also showed interesting cases, and so assisted in keeping the meetings as academic as possible.

During the year, a committee, consisting of Drs. Gordon, Mitchell, Merryweather, and Atkinson, was appointed to watch and report on Dr. Paget's treatment of some cases of phthisis at the Victoria Hospital. After some months' observation, they reported that the treatment seemed to be of no avail.

It was resolved that dependents of members of Friendly Societies going to the war should be treated gratuitously during their absence, and, further, that those members returning incapacitated from work should receive full medical benefits gratuitously during such incapacity.

A number of members have left to give their services for the war. It was arranged to entertain them at a dinner, so as to give them a hearty send-off. However, this was allowed to drop, as some of those going away expressed a wish that the occasion should not be marked by any festivities. One can only hope that there may be an opportunity of welcoming them all safely back during the present year.

#### Statement of Receipts and Expenditure for the Year ended 31st December, 1914.

Receipts.		£	s.	d.
To Balance on Current A/c., W.A. Bank .. ..		39	13	8
" Balance on Fixed Deposits, W.A. Bank .. ..		125	0	0
" Interest .. .. .		1	15	0
" Subscriptions for Year .. .. .		442	0	0
		£608 9 2		
Expenditure.		£	s.	d.
By B.M.A. Head Office .. .. .		142	16	0
Plus Cost of Remittance .. .. .		1	8	6
		144 4 6		
" Australasian Medical Gazette .. .. .		94	18	8
" Subscription to Federal Council .. .. .		5	9	0
" Sundry Expenses—				
Secretary .. .. .	£17	15	0	
Printing .. .. .	8	5	6	
Postage .. .. .	3	0	10	
Rent of Rooms .. .. .	2	2	0	
Williams' Commission .. .. .	0	15	0	
Charge for Bank Account .. .. .	0	5	0	
		32 3 4		
" Credit at Bank, Dec. 31, 1914 .. .. .	96	13	8	
Less Outstanding Cheque .. .. .	40	0	0	
		56 13 8		
" F.D.R., W.A. Bank (£200 due December 24, 1915, £75 due February 8, 1915) .. .. .	275	0	0	
		£608 9 2		
(Signed) HENRY J. LOTZ, President.				
(Signed) W. TRETHOWAN, Treasurer.				
(Signed) THEODORE AMBROSE,				
(Signed) ALLAN E. RANDALL,				
Auditors.				

The following has been elected a member of the Queensland Branch:—

Dr. John Joseph Power, Brisbane,

The following have been nominated for election to the New South Wales Branch:—

Dr. Cecil Aubert Finley, Adelong.

Dr. Ivan C. Harris, Gilgandra.

Dr. Keith B. Gaden, Darling Point.

### Public Health.

#### SMALL-POX IN NEW SOUTH WALES.

The number of small-pox cases reported to the Department of Public Health, New South Wales, for the week ending March 28, 1915, was:—

	Cases.
City of Sydney .. .. .	1
Country—Cessnock .. .. .	1
Total .. .. .	2

#### THE HEALTH OF VICTORIA.

The following notifications have been received by the Department of Public Health, Victoria, for the week ended March 18, 1915:—

Area.	Diphtheria.	Scarlet Fever.	Enteric Fever.	Pulmonary Tuberculosis.
	Cs. D'ths.	Cs. D'ths.	Cs. D'ths.	Cs. D'ths.
Metropolitan .. .. .	45 1	5 0	8 0	12 13
Rest of State .. .. .	72 0	10 0	36 0	12 6
Whole State .. .. .	117 1	15 0	44 0	24 19

The following notifications have been received by the Board of Health, Victoria, for the week ended March 25, 1915:—

Area.	Diphtheria.	Scarlet Fever.	Enteric Fever.	Pulmonary Tuberculosis.
	Cs. D'ths.	Cs. D'ths.	Cs. D'ths.	Cs. D'ths.
Metropolitan .. .. .	50 1	6 —	12 1	19 9
Rest of State .. .. .	65 —	4 —	36 2	13 2
Whole State .. .. .	115 1	10 —	48 3	32 11

#### INFECTIVE DISEASES IN QUEENSLAND.

The following notifications have been received by the Department of Public Health, Queensland, for the week ended March 20, 1915:—

Diseases.	No. of Cases.
Enteric Fever .. .. .	33
Diphtheria .. .. .	42
Pulmonary Tuberculosis .. .. .	7
Scarlet Fever .. .. .	7
Infantile Paralysis .. .. .	7
Erysipelas .. .. .	2
Total .. .. .	98

#### DIPHTHERIA IN QUEENSLAND.

The Council of the Beenleigh Shire, Queensland, has received notice from the Commissioner of Public Health to the effect that, unless satisfactory provision is made for persons resident in the district suffering from diphtheria, an order will be served compelling them to comply with the requirements of the Health Act. It appears that diphtheria has been prevalent in the district for a considerable time, and that the local authority has adopted the simple and convenient expedient of sending the patients by train to Brisbane. The Council on March 24, 1915, recognized the justice of the position taken up by the Department of Public Health, and consequently placed the matter in the hands of a small sub-committee to report at the next meeting.

#### SUBSIDIZED DOCTORS.

The Department of Public Health of New South Wales has appointed Dr. R. C. Lane, of Barmedman to the position of subsidized medical officer at Quambone. The local committee has guaranteed £200 per annum, and the Government £300. Should Dr. Lane earn more than £200 in



fees from his patients at Quambone, the Government subsidy will be diminished to the £700 level. It is suggested that in its own interests the local committee will support the doctor in making patients pay for medical attendance when their means suffice.

## Hospitals.

### THE NEWCASTLE HOSPITAL.

A public meeting was held on March 25, 1915, at Newcastle, for the purpose of finding a way out of the difficulty created by the shortage of funds of the hospital. The President of the Committee pointed out that at Broken Hill and at Wallsend, the local workers had been induced to contribute the sum of three-pence a fortnight, and by so doing became entitled to free treatment at the local hospital. He suggested adopting this expedient at Newcastle. At Broken Hill the employees had contributed a little over half the amount required, and the employers had subscribed the remainder. It was estimated that the expenditure of the Committee would be close on £9,000 after the new buildings were completed. If an annual sum of £4,800 could be raised, in addition to the Government subsidy, the hospital could be maintained in a suitable manner. The proposal was accepted, and it was resolved to approach the employers of labour and the trade unions before the employees were appealed to directly.

### ALEXANDRA HOSPITAL, HOBART.

At a meeting of the Committee of the Alexandra Hospital, Hobart, held on March 19, 1915, it was announced that Dr. H. Nairn Butler had been accepted for active service by the Army Medical authorities, and leave of absence was granted him. Dr. Bettingham Moore had been invited to fill the position of Dr. W. L. Crowther during his absence. The Secretary reported that the extension of the hospital was progressing, and would soon be completed. Electric light had been installed in the older portion of the building and other improvements had been carried out. The cost of the building and of the other innovations had exceeded the amount estimated. On the other hand, the amount realized by the collections made on Hospital Day had been larger than had been anticipated. He intimated that it would be necessary to raise about £200 for the purpose of furnishing the new wards, and asked the members of the Committee to suggest a scheme to attain this end.

### THE AUCKLAND HOSPITAL AND CHARITABLE AID BOARD.

A meeting of the Auckland Hospital and Charitable Aid Board elected the following to the staff of the Hospital. Honorary Physicians: Dr. C. H. Tewsley, F.R.C.S., Ed., Dr. E. H. Williams; honorary surgeons: Dr. C. G. Aickin, F.R.C.S., Eng., Dr. A. Kinder; honorary ophthalmic surgeon: Dr. W. A. Fairclough; honorary surgeon to the nose, ear and throat department: Dr. A. G. Talbot; honorary anaesthetists: Dr. W. Bruce, Dr. G. L. Cawkwell, and Dr. H. F. Holmden; honorary dental surgeon: Mr. J. N. Rishworth. Dr. G. Gore Gillon, F.R.C.S., Ed., was elected honorary consulting surgeon.

The question of offering facilities for clinical study to the students of the Otago University was considered and referred to the Hospital Committee for report.

### AUCKLAND HOSPITAL.

Prof. S. T. Champaloup, the sub-Dean of the Medical School at the University of Otago, has advocated the erection and equipment of a modern bacteriological and pathological laboratory in the Auckland Hospital. A suitable room is available, which, with comparatively little structural alteration, would make an admirable pathological department. He has suggested that the work at present undertaken by Dr. Frost should be divided, that a full-time male pathologist should be appointed, and that Dr. Frost should be offered the post of bacteriologist. The Inspector-General of Hospitals was desirous of making the office of pathologist a Government appointment, and it has been suggested that a suitable Government Pathologist could be

obtained for the hospital at a salary commencing at £600, rising in four years to £700. The matter is now receiving the consideration of the Board of Management.

### HOBART GENERAL HOSPITAL.

At a meeting of the Board of Management of the Hobart General Hospital, held on March 2, 1915, the question of the resignation of two members of the Board was brought up. The resignations were accepted with regret. One of the retiring members wished to place on record his appreciation of the valuable services rendered by the Secretary. The Chairman again protested against the appointment of Dr. McClintock to the second Royal Commission. Other members endorsed what the Chairman had said in criticism of the action of the Chief Secretary. A letter was read from the Secretary of the Royal Commission, informing the Board that the Commission was desirous of giving the Board the fullest opportunity of expressing their views on the management of the hospital. The Secretary asked to be furnished with a list of witnesses who desired to give evidence. He added that the Commission would give consideration to any application the Board might make for representation at the sessions of the Commission, at which evidence would be heard. It was decided that arrangements should be made for members of the Board to give evidence before the Commission.

The following have been appointed Members of the Board of Management of the Adelaide Hospital:—

Mrs. Elizabeth Cullen;  
Mrs. Helen Edwards;  
Mrs. Elizabeth Webb Nicholls;  
The Hon. Alfred Catt, J.P.;  
William Green Coombs, J.P.;  
John Entwistle, J.P.;  
Edward Frinsdorf, J.P.;  
William Thornborough Hayward, M.R.C.S., D.Sc.  
Alfred William Hill, M.D.;  
Ivor MacGillivray, M.P.;  
James Grey Moseley, M.P.;  
Thomas Boden Merry, J.P.;  
Robert Phillips, J.P.;  
William Alfred Robinson, J.P.;  
Richard Sanders Rogers, M.A., M.D.; and  
The Hon. Alfred William Styles, M.L.C.

### THE HOSPITAL IN BELLINGEN.

The Bellinghen Hospital is to be closed on account of want of funds. The Government is stated to have promised a grant of £500, but the money has not been paid. The institution is in debt, and can no longer meet the minimum expenses for maintenance.

## University Intelligence.

### MELBOURNE UNIVERSITY.

(By Our Special Correspondent.)

At a meeting of the Melbourne University Sports' Union, held towards the end of February, the following resolutions were unanimously passed:—

In the opinion of the Melbourne University Sports' Union, considering the present extraordinary conditions and the fact that many of the various sports clubs have been deprived of the services of players owing to their leaving Victoria on active service, and as it is probable that many more will still volunteer, it is advisable that—  
(1) Sports should not be suspended, but should be played for competitive exercise only, and (2) matches should be arranged by the governing bodies of athletic sports in Melbourne, but that no premiership or pennant honours should be awarded during the 1915 season. That a copy of the above resolution be sent to the governing body of that sport, in which the University is usually represented.

That it be a recommendation from the University Sports' Union council to the various sports clubs in the union that in consequence of the present extraordinary conditions, no inter-University sports matches

be held during 1915, and that this recommendation be communicated to the sports authorities of other Australian universities.

After careful consideration and discussion, the sports clubs of the affiliated colleges—Trinity, Ormond and Queen's—have decided that the inter-collegiate contests shall take place as usual, the majority having held that they are of a less public character than pennant and inter-University contests, and, further, that they play a not unimportant part in the education and general life of resident students.

At the present time, there are upwards of 340 members of the University—past and present students—on active service. This number includes 27 members of the teaching staffs of the University and the recognized clinical schools.

Professor R. S. Wallace, who, in a previous issue, was reported to have accepted a commission and gone to the front on active service, has returned to Melbourne. The cable, granting him leave of absence, did not reach England in time to allow of his sailing with his regiment, which was ordered to France in January, and his place was consequently filled. His return was quite unexpected, as a cable sent by him from Aberdeen, announcing these facts, was only delivered at the University on his causing enquiries to be made after his return, on Monday, March 22, 1915. Meanwhile, a somewhat awkward position has been created, as the Council has appointed an Acting Professor and Acting Lecturer to carry on the work of the chair.

Dr. M. D. Silberberg has been appointed Stewart Scholar in Medicine, and Dr. W. J. Denehy, Stewart Scholar in Surgery, for the ensuing year.

#### AUCKLAND AND THE OTAGO UNIVERSITY.

Some discontent and much dispute have arisen in regard to the position of Auckland and the New Zealand University at Otago. For several years it has been recognized that New Zealand was not populous enough to justify the establishment of more than one university. Auckland, with the largest population of the four capital cities, namely, 110,000, has begun to feel that the plan of dividing with the three other cities the educational facilities provided for under the university scheme is not wholly desirable. The fact that there are four separate university colleges make it inevitable that some specializing should be indulged in at each. At the Canterbury College it appears that engineering has been developed to a not inconsiderable extent. In this way, the engineering students have had to leave Auckland and to complete their education in the southern island. The Auckland School for Engineering has been forced to take a secondary place, and as a result, the proposal has been brought forward for the emancipation of Auckland and for the establishment of an Auckland University. Opposition to this scheme is making itself heard in Christchurch and elsewhere in the Dominion.

The following have been appointed Junior Demonstrators in Anatomy at the Sydney University for the year 1915:—

Drs. N. D. Royle, R. A. R. Green, and C. J. Wiley.

### Vital Statistics.

#### ANNUAL RETURNS FOR NEWCASTLE DISTRICT.

The Government Statistician of New South Wales has issued the vital statistics affecting the population of the Newcastle District for the year 1914. He is to be congratulated on the production of this report within the first two and a half months of the year following that dealt with.

The population of the district is estimated at 58,650. During the year, 2,078 births were registered. Forty-two of the infants were born in public institutions. The birth-rate is given at 35.89 per 1,000 of population. The Statistician points out that this rate is 14% above the average rate of the preceding five years. Included in the 2,087 children born were 110 illegitimate children. The illegitimate birth-rate is given at 1.89 per 1,000 of population. In every 100 births 5.27 were illegitimate. The illegitimate birth-rate was highest in Newcastle city (1.92 per 1,000 of population) and lowest in Stockton (0.46).

The number of deaths registered during the year was 685, which is equal to a death-rate of 11.78 per 1,000 of population. In 1905 the rate was 14.29, in 1907 it was 13.1, in 1910 it was 10.45, in 1912 it was 13.7, and in 1913 it was 12.53. A more marked reduction is recorded in connexion with the infantile mortality. The actual number of deaths of children under one year of age was 157. The infantile death-rate worked out at 75 per 1,000 births. In 1910 the rate was 74, and in 1911 68, but with the exception of these two years the rate has been persistently higher since 1905. The average for the past 10 years was 89.4.

In regard to the causes of death, diseases of the cardiovascular system, including cerebral hæmorrhage, were by far the most common. One hundred and four persons died of these diseases, 50 of whom were suffering from organic diseases of the heart, and 26 from cerebral hæmorrhage. The acute infective diseases were apparently not very common with the exception of diarrhoea and enteritis, which caused 66 deaths, 52 of which affected children under two years of age. Seven individuals died of diphtheria, 5 each of enteric fever and influenza, 4 of erysipelas, 3 acute rheumatism, 28 of pneumonia, 13 of acute bronchitis, 11 of broncho-pneumonia, 2 of tetanus, 2 of whooping-cough, 1 of malaria, 1 of cerebro-spinal meningitis, and 1 of syphilis. Thirty-one persons died of tuberculosis. In 2 of these cases, the disease took the form of an acute miliary infection. Death was ascribed to cancer in 39 cases. In 14, the patients were males, and the site of the tumour was the stomach and liver 5 times, peritoneum and intestines 3 times, and skin twice. Of the 25 women who died of malignant disease, 9 were suffering from uterine or ovarian cancer, 5 from cancer of the stomach or liver, 3 from cancer of the breast, 3 from cancer of the skin, and 2 growths in the peritoneum and intestine.

There were 16 deaths of women in the pregnant or parturient condition. In 4 cases death was due to puerperal septicæmia, in 4 to puerperal albuminuria, convulsions (? eclampsia), in 2 to puerperal hæmorrhage, in 2 to "other accidents at childbirth," in 2 to illegal operations, and in 1 to accidents of pregnancy.

The causes of infantile death was tabulated in the usual unsatisfactory manner. There were 44 cases of premature birth leading to the death of the child, 22 of "congenital debility, icterus and sclerema," 7 of congenital malformation, and 4 of injury at birth.

One hundred and eighty-two of the deaths took place in public institutions. Of these, 137 occurred in the Newcastle Hospital, and 14 in the various hospitals for the insane.

#### SOUTH AUSTRALIA.

The following returns of the vital statistics of South Australia for the month of February, 1915, have been issued. The population is estimated at 440,047. During the month 935 births were registered, which is equivalent to an annual birth-rate of 25.44 per 1,000 of population. In the city of Adelaide, with an estimated population of 43,438, 98 births were registered, which is equivalent to an annual birth-rate of 27.12.

In the whole State, 355 deaths were registered, of which 151 affected persons 50 years or over, and 62 children of under 1 year of age. The death-rate is equivalent to an annual death-rate of 9.72 per 1,000 of population. In February of 1910, 1913, and 1914, the death-rate was exactly the same, while in the corresponding months of 1911 it was slightly lower, and of that in 1912 it was slightly higher. In the city of Adelaide 78 deaths took place. Twenty-four of these persons were usually resident outside the city. The corrected death-rate for the city was, therefore, equal to an annual rate of 16.88.

The table containing the causes of death for the whole State revealed that 56 deaths were due to affections of the cardio-vascular system. Among the infective diseases, tuberculosis was the most common, ending fatally in 33 cases, of which 25 were instances of pulmonary tuberculosis. Diarrhoea and enteritis is entered 21 times, 20 times affecting children under 2 years of age, and 17 times children under 1 year of age. Diphtheria proved fatal in six cases. Two persons died of enteric fever, 2 of dysentery, 1 of measles, 1 of influenza, 1 of erysipelas, 14 of pneumonia, and 4 of meningitis. Among the non-infective diseases, cancer is entered as causing 25 deaths.

There were no deaths from puerperal septicæmia, and there was only one in connexion with pregnancy. Eighteen infants died of premature birth, in 6 cases death is ascribed to congenital debility, icterus, etc., and in 5 cases congenital malformation are registered.

#### CHARITABLE AND OTHER INSTITUTIONS IN SOUTH AUSTRALIA.

Part VII. of the Statistical Register of the State of South Australia, for the year 1913 contains details concerning religious, educational and charitable institutions.

##### Educational.

According to the census of 1911, among a population of 408,558 336,829 persons could read and write, 1,739 could read, but not write, and 61,878, including 47,530 infants under 5 years of age, could neither read nor write. A better conception of the elementary education of the population is obtained from the figures dealing with persons of 20 years and upwards. The total was 236,961. Of this number 5,051 could not read, which yields a illiteracy rate of 2.13%. There were approximately 122,200 persons between the ages of 5 and 19, and of these close on 63,500 were "being educated," by which we presume that they were attending school. The number of children attending primary and high schools was 56,353, and the average attendance worked out at 41,533. The cost was: £3 18s. 3½d. per child instructed, and £5 6s. 2¼d. per child in average attendance.

The number of scholarships granted during the year was as follows:—Public school exhibitions, 9; exhibitions, 13; senior exhibitions, 12; Government bursaries, 12; University studentships, 18; and "Thomas Price" scholarship, 1. There were 415 undergraduates at the University of Adelaide, of whom 318 were attending at the conservatorium. The B.A. degree was conferred to 11 males and 6 females, and the M.A. to 3 males and 1 female. The degree of M.B. was conferred on 11 males and the degree of M.D. on one male. One candidate obtained the degree of D.Sc., and five that of B.Sc. Since the foundation of the University 194 persons obtained the M.B., and 56 the M.D. Three received the Ch.M. In all 84 degrees were conferred during the year, 73 to males and 11 to females. Scholarships were granted to the best students in the 1st, 2nd, 3rd, 4th and 5th years, while the David Murray Scholarship for the best thesis for the M.D., M.S. was not awarded.

No information is given in regard to the records obtained in connexion with the health of school children.

##### Lunatic Asylums.

During the year 1913 1,354 insane persons were treated in the various asylums of the State. In 1904 there were 1,219, and the increase during the subsequent years was comparatively regular. Of this number 272 were fresh cases, including 256 first admissions and 16 second or subsequent admissions. One hundred and ten patients died, and 162 were discharged. In 147 cases the mental affection is stated to have been improved; in 6 no improvement had taken place; and in 9 recovery is reported. The ratio of persons admitted to the asylums to the population was 1 in 1,618 in 1913. A distinct improvement is recorded in this respect since the year 1904, when the ratio was 1 in 1,398.

In regard to the duration of the disease in the patients who died during the year, mental deficiency without epilepsy was present in one patient for over 12 and under 25 years, and in 8 for over 25 years. The same condition associated with epilepsy had lasted on one occasion for between 10 and 15 years, and in 2 for over 25 years. Epileptic insanity had been present in 4 cases for 2 years; in 1 case for over 5 years, in 1 for over 10 years, in 1 for over 15 years, and in 4 for over 25 years. Of the 8 general paralytics under treatment, 4 had been ill for one year, 3 for two years, and 1 for 3 years. Seventeen patients had suffered from manic-depressive insanity for periods varying from one month to over 25 years. The length of the attack of delusional insanity was between 5 and 10 years in 2 cases, under 15 years in 1 case, and over 15 years in 2 cases. With the exception of 1 case, in which the disorder had lasted for more than 25 years, the duration of the cases of senile dementia was between 6 months and 5 years.

The percentage of the recoveries (including cases tabulated as "relieved") in 1913 was 59.5. In the period 1846-1860 the percentage was 55.3. The lowest recorded percentage was 41.1, in 1906, and the highest was 81 in 1865. The average for the whole period was 57.2. In regard to the death-rate calculated on the average number of patients resident in the asylums, no distinct improvement is recorded. In 1861 it was 6.5%, and in 1913 it was 10%. The highest rate was 12.8%, in 1903, and the lowest was 5.2%, in 1867. The average since 1861 works out at 9.2%. The number of relapses has varied within wide limits since 1865. As stated above, there were 16 in 1913. In 1872 there were only 2, while in 1893 there were 66. In the course of 67 years 9,957 persons were admitted into the asylums, and of this number 1,575 had been in the asylums previously.

On the assumption that the number of persons confined in asylums indicate the frequency of insanity, a table has been worked out showing the ratio of the insane to the total population during the past 10 years. From these figures it would appear that insanity is considerably more common in South Australia in 1904 than it was in 1913. In 1913 2.46 lunatics, idiots, and persons of insane minds were found to each thousand of the population, while in 1904 the number was 2.71.

The last table deals with the expenditure on the insane and their maintenance in asylums. In spite of the fact that the number of patients treated in 1913 was only 1% more than that treated in 1904, the expenditure increased from £27,512 to £36,407. The amount spent on salaries and allowances was about £16,670, or approximately £5,000 more than the corresponding items in the 1904 account. The daily average cost of each patient in 1904 was 1s. 6½d., and in 1913 1s. 10½d. During the year 1913 £7,500 was received as fees for maintenance. The daily average cost of each patient, after deducting the fees paid for maintenance, was therefore 1s. 5½d. The corresponding figure for 1904 was 1s.

##### Hospitals.

The Statistician gives some details concerning the 23 public hospitals of South Australia. In all 95 medical practitioners filled positions in these hospitals. The permanent staff at 17 of these hospitals embraced 27 male practitioners. In the Adelaide Hospital there were nine members of the permanent staff, in the Adelaide Children's Hospital there were 2, and in the Burra Hospital there were 2. In all the others only one resident or permanent medical officer was employed. In six of the hospitals no permanent staff existed. At the Adelaide Hospital the honorary staff consisted of 31 males and 1 female officers. At the Adelaide Children's Hospital there were 21 males and 2 female honorary medical officers. At the Blyth Hospital there were 1 male and 1 female honorary medical officer, and at the Port Pirie Hospital there were 2 male honorary medical officers. Only one honorary medical officer was attached to the Bolleroo Centre Hospital, to the Jervois County Hospital, to the Maitland Hospital, to the Naracoorte Hospital, to the Pinnaroo Hospital, to the Port Lincoln Hospital, and to the Yorketown Hospital. The nursing staff at the 23 hospitals comprised of 254 nurses. In 2 of the hospitals there was only 1 nurse; in 3 others there were 2; in 6 others there were 3; in 3 others there were 4; in 2 there were 6; in 2 there were 7; in 1 there was 8; in 1 there was 9, and in 1 there was 14. At the Adelaide Hospital there were 129 nurses, and at the Children's Hospital there were 30. In addition to the nurses there were 42 male and 76 female attendants and other employees at the Adelaide Hospital, and 3 male and 12 female at the Children's Hospital. The other hospitals employed a small number of attendants and servants. At the Adelaide Hospital there was 1 resident medical officer to every 40 patients, 1 honorary medical officer to every 11 patients, and 1 nurse to every 3 patients. At the Children's Hospital there was 1 resident medical officer to every 38 patients, 1 honorary medical officer to every 3 patients, and 1 nurse to every 2½ patients. The Adelaide Hospital, including the Consumptive Home and the Infective Diseases block, contains 420 beds, 230 of which were on the male side, and 187 on the female side. The daily average of patients was 201 males and 163 females. The total number of persons treated during the year was 5,169. Of this number 334 were still under treatment at the



end of the year. Four hundred and ninety patients died, 436 were discharged unrelieved, 1,445 were discharged relieved, and 2,464 were discharged recovered or convalescent. The average length of residence in hospital of patients discharged during the year was 32 days, and of those who died in the hospital 34 days.

The Adelaide Children's Hospital contained 96 beds, and the number of children under treatment during the year was 984. Of these 66 were in the hospital at the beginning of the year, and 83 remained at the end. The average number of beds occupied works out at 77. As is usually the case in children's hospitals, the mortality was high, no less than 109 of the 984 having died. Recovery or convalescence was achieved in 631 cases, improvement in 127, and in the remaining 24 the condition was unrelieved.

At the Port Augusta Hospital there were 58 beds, but the average daily number of patients was only 22. At the Port Pirie Hospital, where there were 49 beds, the average daily residence was 37. During the year 376 patients were treated at Port Augusta, and 668 at Port Pirie. At the former hospital 28 deaths occurred, and at the latter 44.

Information is given of the nature of the diseases dealt with at the various public hospitals. Diseases of the cardiovascular system accounted for 512 cases, and 103 deaths. Of these, organic disease of the heart was met with 220 times, and ended fatally on 62 occasions. Cerebral hæmorrhage occurred 42 times, causing 18 deaths. Malignant disease occurred 313 times, and led to death in 73 instances. The most common of the infective diseases was diphtheria, of which 572 cases were dealt with. In 38 of these cases death occurred, giving a case mortality of 5.62%. There were 449 cases of tuberculosis, including 266 of the lungs, with 81 deaths, and 19 of the meninges, with 16 deaths. Enteric fever comes third on the list, 299 cases having been treated. Death occurred in 35 cases, which is equal to a case mortality of 11.7%. Influenza was treated on 120 occasions without any deaths, erysipelas on 61 occasions with 5 deaths; morbilli on 85 occasions, with 1 death; scarlatina on 83 occasions, with 3 deaths; and pertussis on 35 occasions, with 11 deaths. Tetanus occurred 11 times, and led to death 5 times; while beri-beri occurred 11 times, proving fatal once. There were 9 cases of dysentery, 2 of which proved fatal, 11 of simple meningitis, with 9 deaths, and 4 of cerebral-spinal fever, all of which proved fatal. In regard to venereal disease, 110 patients were treated for primary, secondary, tertiary and hereditary syphilis, 4 for soft chancre, and 106 for gonorrhoea. Pneumonia was met with on 257 occasions. In 50 cases it proved fatal, which gives a case mortality of 19.45%. There were 68 cases of broncho-pneumonia, with 13 deaths; 76 cases of chronic bronchitis, with 3 deaths, and 64 cases of acute bronchitis without any deaths. Diarrhoea and enteritis occurred 134 times, in 70 of which the patients were under 2 years of age. Eighteen of the little patients died, i.e., the case mortality of 25.7%, while only 1 of the elder patients succumbed.

Lead poisoning was treated 62 times, and once proved fatal. There were 220 cases of alcoholism, exclusive of its sequelæ. Six of these patients died. One hundred and seventy-three infants were admitted for diseases or conditions peculiar to infancy, and including 123 cases of nurslings discharged from hospitals without disease. Twenty-nine of the infants died. Among the gynaecological conditions, of which there were 408, non-malignant diseases of the uterus occurred 292 times, and were fatal 10 times.

In the realm of obstetrics, 594 patients received treatment. Of this number 286 were delivered under normal conditions, and 1 patient died. There were 220 cases of accidents of pregnancy, with 6 deaths; 38 cases of puerperal septicæmia, with 9 deaths; 3 cases of puerperal hæmorrhage; 4 cases of eclampsia, with 1 death; and 28 cases classified as "other accidents of labour," with 2 deaths.

The table includes a large number of further details in regard to the diseases under treatment.

A separate table concludes this part of the report, and deals with the number of admissions, discharges, and deaths in, and the revenue and expenditure of, the various charitable institutions.

## Medico-Legal.

### CRIMINAL ABORTION.

On January 18, 1915, Thomas Hodgson, M.B. (Melb.), a medical practitioner residing at 49 Brunswick Street, Fitzroy, Melbourne, and Kathleen Graham, a married woman, were charged in the Criminal Court with having performed an illegal operation on a girl named Rose Forbes. The counsel for the male prisoner claimed that the two cases should be tried separately, and this application was granted. The female prisoner was tried by Mr. Justice Hood on February 19. After a trial lasting for three days, the jury failed to agree.

On March 17, 1915, she was again brought up for trial, the case being heard in the Criminal Court by the Acting Chief Justice. The evidence went to show that the girl Rose Forbes was *enette*, and desired to terminate her pregnancy. According to her story, she and a man named Ralph Carey, applied to the female accused, who was alleged to have given out that she "fixed up" maternity cases. It was arranged that for the sum of fifteen guineas an operation should be performed without an anæsthetic. This was agreed to, and the girl attended Graham's house, where she paid the amount, and, after an instrument had been used, the female defendant stated that she had done her part, and that the doctor would do the rest. She also stated that while at the woman's house, she was asked to tell another girl that the manipulations did not hurt, and that she would get through it all right. She then was taken to Dr. Hodgson's house, and a further operation was performed by him. She stated that no questions were asked, and that no examination preceded the passage of the instrument. The witness also stated that when taken with Graham to the Detective Office, the woman told her "to know nothing." She volunteered a statement, although she swore that she did not know that by so doing she was saving herself from prosecution.

The female accused denied that she had used an instrument or that she had attempted to bring about a termination of the pregnancy. The girl was in her house for nearly a week. In his summing up, his Honour pointed out to the jury that Rose Forbes has no cause for ill-feeling against Graham. The latter had done what she was paid to do, if Forbes's story were true, and had been paid a substantial sum to safeguard her from the shocking consequences which often followed a particular operation when practised by unskilled persons. She would therefore not have obvious reason for false swearing. He emphasized the fact that either Graham or Forbes had deliberately lied, and the jury must determine which of the two it was. The jury found the female prisoner guilty. After some suggestions, it was agreed that his Honour should state a case on the question of law, and that the points would be argued before the Full Court.

On March 23, 1915, Thomas Hodgson was tried in the Criminal Court by the Acting Chief Justice.

The counsel for the prosecution proposed to place before the Court evidence that the accused had acted in conjunction with the woman Graham. He contended that both Hodgson and Graham had used instruments for the purpose of procuring abortion, and that they were both criminally answerable. The evidence was substantially the same as in the former case.

Ralph Carey, of Launceston, Tasmania, stated that Rose Forbes told him of her condition on December 24, 1914. He visited accused's surgery, and asked him if he "fixed up" maternity cases." The reply was in the affirmative, and Hodgson told him that his fee would be £35. He also called on Graham, who told him that she undertook "maternity cases" for fifteen guineas without chloroform, and twenty guineas with. Rose Forbes stayed at Graham's house for three days. Rose Forbes stated that while at Graham's house, the female prisoner used an instrument on her. Later she was taken to the male prisoner's house, where she was placed on a chair or couch, strapped down and, while in this position, several instruments were passed during a period of about 15 minutes.

A witness named Francis McLennan said that she applied to Graham for a certain purpose, and that instruments were passed by her. At a later date, she went to Hodgson's

surgery. Hodgson passed several instruments. Evidence was also given to the effect that when Rose Forbes was brought to the house where Graham and Hodgson were arrested, she recognized the latter as the man who had operated on her. Dr. L. R. Cook, of the Women's Hospital, deposed to having examined the two girls, and stated that there were indications of instruments having been passed on each.

For the Crown, Mr. Woinarski contended that there had been collusion between Graham and Hodgson. The defence relied on the absence of direct evidence of collusion or of any written or spoken contract between the two accused persons.

In the summing up, his Honour made it quite clear that great care must be exercised in accepting the evidence of accomplices. Both Rose Forbes and Francis McLennan were in a sense accomplices, but they admitted the part they had played and they had not been active in the attainment of the desired result. In regard to the evidence of collusion, the jury must be satisfied that the Crown had produced actual evidence of guilt. In order to assist the jury, he put in writing his opinion of the matter in question. They had to consider the question: Are you satisfied that the accused did what he did to Miss Forbes under an arrangement with Mrs. Graham to complete the process of procuring a certain event begun by her? If they were satisfied that this was so, and if there was no reasonable doubt in their minds, then the verdict must be "guilty." The facts were plain. Forbes was taken to Graham's house for a certain purpose. She was then taken to Hodgson's surgery, and subjected to certain treatment. That Graham had said that the doctor would do the rest was merely evidence that she took upon herself the position of a person acting in concert with the accused. The jury must determine whether she took this position truly or without justification. Dr. Hodgson had admitted to the detectives that he received six guineas for certain operations on women. That did not suggest a different bargain in each case, but an arrangement between Mrs. Graham and the accused, that certain work should be done for payment. If the jury thought that, it went a very long way to establishing the existence of an arrangement. The accused had stated that he had performed a certain operation, as Forbes's condition necessitated early treatment. If the accused knew how the condition had been brought about, then he had placed himself in a position in regard to Mrs. Graham, in which he was to be relied upon as her assistant, in completing the process which made a certain event inevitable. He had not visited the girl after the operation, which a careful practitioner would have done. If the jury came to the conclusion that the accused had willingly finished what Mrs. Graham had begun, the verdict must be against the accused. The counsel for the defence regarded the evidence of collusion so weak and insufficient that the jury should not bring their minds to bear on it. His Honour did not agree with that view, but left the jury to weigh the whole evidence.

After the jury had enquired of the Acting Chief Justice whether they were to base their decision on circumstantial evidence, and having received an affirmative reply, a verdict of "guilty" was returned.

His Honour agreed to state a case for the consideration of the Full Court, and the accused was liberated on bail, pending the hearing.

## Correspondence.

### WHITE AUSTRALIA POLICY.

Sir,—A scientific truth is established only when it is proved by experiment. Till then it is a theory, and often a pious opinion. Professor Hill's incursion into the white Australia policy is of this class, for when it is tested it does not explain the facts. More than that, it is contrary to fact in some cases. There is nothing new in it. It is simply Aristotle up-to-date. It is all so simple. "Some men are black and some are white. The white men, when exposed to the rays of the sun, get dark-skinned. The men who lived in hot climates were mostly black. Therefore, black men were so because they lived in a hot climate, were better suited for a hot climate," and as many more de-

ductions, prompted by racial or other prejudices, as you wished. If it is true that "the pigment of a black man's skin arrests the passage of the sun's rays, converts their energy into heat and evaporates it," then nature does not recognize the fact in animal colouring, and confines it to man alone. As a matter of fact, she does not even recognize it in man. The coast tribes of Terra del Fuego and the forest tribes of tropical Brazil continue to resemble each other in spite of the extreme differences of climate and food. There is little difference between pure Arabs and Swedes. The mongoloid type, with its yellowish-brown complexion, black eyes and straight, black hair, prevails over the vast area extending from Lapland to Siam. Coloured men inhabit the whole of North America, from freezing Alaska to torrid Florida. In fact, so small is the colour variation in mankind that anthropologists have had to abandon it for classification purposes. It is quite obvious, if the pigment absorption theory is sound, that nature has not taken much notice of its soundness. When I lived in the tropics, coloured men were affected by the direct rays of the sun as much as anyone else. They were wiser and were adepts in finding shade and sleeping until it got cooler. If, again, it is true that "the skin of a white man permits the passage of those rays which are transformed into heat in the deeper tissues of the body, and so can cause injuries varying in violence from sunburn to sunstroke," whence comes it that those who suffer most in hot climates are they who are compelled to pass most of their time indoors, where the direct rays of the sun never penetrate? What are these "injuries." If menstrual troubles are meant, and, possibly, anæmia, they are no commoner than in countries such as England or America. This "heat in the deeper tissues" is a myth. Professor Hill must use some method besides the clinical thermometer to find it. With a temperature above 110° F. for over twelve days, I was not able to find it in man, woman or child. The last "incontrovertible truth," is, however, the most amusing to the practical physician. We are told that "the wearing of clothes tends to arrest the loss of body heat by evaporation of sweat, and, when associated with the pressure of a wet bulb temperature, physical depression can ensue, culminating in a heat stroke." If people wore furs or cheviots in the tropics there might be some point in this. But they do not. Neither do they in Rome, London or New York in the hot weather. Also, it is a commonplace that drinking freely makes you feel the heat more in hot climates. Yet that would be untrue if perspiration and coolness were interchangeable terms. Physical depression is as common amongst those who wear clothes as amongst those who wear little or none. Heat stroke is commonest amongst those who work laboriously and who are precluded from "physical depression" by the nature of their occupation. So that the inferences drawn by your correspondent—"M.B."—from a comparison of black man and white "clad and suffering from being clad" are incorrect, inasmuch as they depend on the clothing being sufficient "to prevent evaporation of sweat"—which it never is in the tropics.

The question at issue is not whether white men (sic) can "contentedly and economically exploit the Territory." That is the purely commercial aspect. The real question is this, "Is it advisable to let another race take it on from a national or moral point of view?" History answers, No! Commonwealth law must rule the Territory, or we establish a new race at our back door. We break down our greatest bulwark, the sea around our coasts, by doing so. And if Commonwealth law is to rule the Territory, we will then impose on those who do not understand it, laws, which they cannot comprehend and only obey when there is force at the back of them. Sociology answers, No. Where there is coloured servile labour, the working white man becomes "white trash." Rome perished when the work of Cincinnatus was handed to a slave. Morality answers No. It is the universal experience that all races have despised the half caste.

Now what does "M.B." urge as against all this? He mentions "the weary white man leaning against a post, the Australian at work and play, with his slouching gait and listless manner," "the eight hours movement was inaugurated by exhausted stonemasons, exasperated into revolt by heat pressure," "two instances of aboriginal pugilists, who met white men in the ring," "one man who

works from morning to night—a Chinaman." Verily, this is poor talk for a scientific man to utter.

Let us for once leave generalities, and assert facts known to ourselves. In the height of summer three men, Australian born, comprising father, set. 51, and two sons, set. 22 and 20, walked from Kilmorey to Amby, 41 miles, carrying water-bags, in addition to their clothes, etc., in one day, averaging three miles per hour, and three short stops for tea. They slept soundly all night, and started work next day. Their usual diet is salt junk, damper and tea, with sugar. The sons are magnificent 6 ft. specimens, not bronzed at all. Another man, aged 46, is in hospital at present with a comminuted fracture of the leg, caused by his horse rolling on him. When injured, he dragged himself a quarter of a mile on to a track and laid there, exposed to dust and sun and insects for four hours. He was picked up by a youth on a bicycle, who carried him (12½ st.) on his back a distance of 12 miles. The patient was then brought in 14 miles in a spring cart, and was cheerful on arrival. A gentleman, 70 years of age, is the fourth generation of Australian, has never been laid up in bed, and is as lively as a cricket. A young man came last week with the top of his finger torn off by wire. After it was attended to, he went back to look after the stock, as he knew the place "better than those at home." Another walked 15 miles to bring me a message, as his horse got away. He would not wait for a cup of tea, because "if he didn't get back at once the horse might get into the ranges and be lost." I see drovers and others from every part of the Territory and Queensland. It is always the same tale. It may be news to many to know the favorite game after work is—tennis.

What an absurdity it is, therefore, to assert that "to acclimatize is to pigment or enervate, or both." My experience is that pigmentation is not transmissible, that it is pathological, as in Addison's disease, and that it is no commoner than in France, Spain or Italy. I have brought several hundred children into the world in Queensland, coming from all parts, and I have never seen it once. Mixed marriages have yielded pure white, pure black and various shades of colour between, as might be expected. And a knowledge of Mendel's law explains the "Berber (?) with the Caucasian (?) features and jet black skin," but nothing explains the Arab with the white skin, unless we assume that man evolved from several Simian roots and not from one. However, I am open to learn of one case, scientifically asserted, where a white skinned man acquired pigmentation and transmitted it to his offspring as a fixed character.

It is altogether incorrect to assert that black labour "develops" a country if we mean by "develop" that it induces and creates a stable civilization, producing enough for its own needs and for foreign exchange, and able to protect itself against the rest of the world. Liberia is the classic instance to the contrary. All races have not been endowed with the genius of colonization, though many have the genius of conquest. Coolies, without their natural leaders, are merely slaves. With their natural leaders, we ourselves are likely to be slaves instead. Gibbon gives eloquent testimony in his "Decline of Imperial Rome." Admit intellect, if you will, but keep out the coolie. You pay a compliment to intellect. But to admit the coolie and exclude intellect is an insult. You brand half the human race as field chattels, as willing to do work that the white man despises. You assert that they do not need clothes or comforts, or intellectual or bodily ease, or regular hours of labour or political rights, ambitions, loves, hopes, or joys. As the Bishop of Travancore said, "Christianity aims at raising the down-trodden Indian coolie to the level of the white man. We are teaching them they have souls to be saved. We are demanding that they have time for religious duties, for self-improvement and for greater and purer enjoyment of life." The question naturally arises as to whether the Black Australian advocates wish to improve the coloured labourer or to improve themselves and let the coolie remain intellectually the same as since the dawn of history?

"M.B." is not strong on induction. So I am not at all surprised to find his rhetoric weak. The White Australia Policy "is poor business, because it will excite reprisals." From whom, pray? Surely not from the hordes of Javanese low-caste Hindoos, Chinese negroes and others

whom we exclude. The earth is at present shaken, because one little nation asserted her right to conduct her affairs in her own way and in her own territory. "It is bad science, because there is only race prejudice to support it." This is a new definition of science. But probably "M.B." has an up-to-date definition of his own. So we may let it pass. "It is worse morals, because it repudiates the ideals of western civilization, and must create strife." Now, just what ideal of western civilization does it repudiate? Even England has its alien law exclusion.

Then, lastly, we are informed that "Australia will never be developed by white labour, because the labourers in the field must have the protection of pigment." This must be news to the farmers in the southern States. But probably the millions of pounds in value of farm produce consumed and exported has produced itself. Perhaps "M.B." thought that Victoria was in the tropics, or more probably he writes unthinkingly. As for Queensland, as far as I know, it is preposterously incorrect. Our curse in hot climates is alcohol, where only whites are concerned. Where there is an admixture of races, the dangers are alcohol and syphilis. And my experience is that it is not the white man's clothes which deteriorates the natives physically, but the white man's vices. Clothe and feed them properly and they live healthier and longer lives than they did in the old tribal days.

Yours, etc.,

JAS. F. MERRILLEES.

Roma, Queensland,  
March 24, 1915.

#### OTOGENIC CEREBRAL ABSCESS.

Sir,—In the last number (March 27) of the *Medical Journal of Australia* my remarks are not quite correctly given concerning a case I showed of complete recovery after operation on a boy who had a large otitic cerebral abscess.

The report states that four weeks prior to admission he had been under Dr. Lewers at another hospital. As a matter of fact I stated that the patient had been admitted to St. Vincent's Hospital under Dr. Lewers, and that Dr. Lewers asked me as ear specialist to that hospital to examine him, as he suspected cerebral abscess of otitic origin. I examined him, and found that he had chronic suppurative otitis of four years' duration, and confirmed the diagnosis of Dr. Lewers.

I did a radical mastoid operation, explored the brain, and later trephined, evacuating a large abscess of the brain with complete recovery of the patient, who was shown at the meeting of the Victorian Branch of the British Medical Association, on March 3rd, 1915.

In justice to Dr. Lewers I request the publication of this note, as the diagnosis of abscess of the brain was first made by Dr. Lewers.

Yours, etc.,

JOHN MURPHY, M.D., F.R.C.S.

Melbourne (Undated).

Dr. John Murphy supplied the following note in reference to this case:—"Dr. John Murphy showed a case of otogenic abscess following suppurating ear. The case is fully reported in the *Australian Medical Journal*, 23/8/13. The patient—a boy aged 16—was under the care of Dr. Lewers at St. Vincent's Hospital. Four weeks prior to admission to the hospital he had severe headaches—he had a suppurating ear for four years—there was optic neuritis and some paresis on the side opposite the bad ear."

We regret that in the account published on page 296 (March 27, 1915) the facts were not correctly stated. It will be seen that the note supplied is not definite and does not contain the details now given by Dr. Murphy.

#### MALARIA IN NEW SOUTH WALES.

Sir,—That Dr. Cleland, in his official note from the Government Bureau of Microbiology, should cast some doubt on the authenticity of my case of locally-infected tertian malaria does not altogether surprise me.

Previous experience has taught me that this is the usual custom of the professional staff of the Board of Health, for on several occasions my diagnosis in cases reported under the Notification of Diseases Act has been disputed, but that the objections raised to the acceptance of my diagnosis are not always well founded is evidenced by one instance I will now narrate.

In 1913, about 10 days before the Board of Health officials notified the public that small-pox was prevalent (and widely



so), I saw in one of the wards of the Sydney Hospital a case which, to my mind, so closely resembled variola that I demonstrated it as such to my students.

Having done so, I requested the Medical Superintendent to report the case as definitely one of variola to the authorities.

This was accordingly done, and, as a measure of precaution, the students, the nurses, and the other patients in the ward were at once vaccinated.

I was much surprised to learn shortly afterwards that the officials of the Board of Health did not regard the case as one of variola, but rather as one of severe varicella.

The reported case was not removed from the hospital at once, but remained for some little time before being removed to the Coast Hospital.

At a later period, the existence of small-pox in an epidemic form was announced by the President of the Board of Health.

At a still later period a lantern demonstration of cases was made before the members of the British Medical Association by one of the officials of the Board of Health, when, to my great surprise, among those cases which were regarded as typical was shown this very case which I had seen in the Sydney Hospital!

This then is one instance in which the diagnostic infallibility of the professional staff of the Board of Health has not been sustained, but I can give at least two other instances equally convincing if necessary.

I should now like to deal with a few of the points referred to by Dr. Cleland in his official note.

After referring to the views of Sir Ronald Ross on the conditions essential to the establishment of a malarial centre, a certain density of population, a considerable degree of prevalence of anophiline mosquitoes, and a certain percentage of infected human beings to act as a reservoir, he proceeds to mention that steps have been taken to ascertain the prevalence of anophiline mosquitoes in New South Wales.

As the result of a research conducted by Dr. E. W. Ferguson and himself he concluded that throughout the Southern States of Australia, the *Nyssorhynchus annulipes*, the presumed transmitter of malaria in Australia, is widely distributed, but as a rule in such small numbers as to lead to no danger of the spread of malarial fever thereby.

Unfortunately, Dr. Cleland does not take us into his confidence as to the exact nature of the steps taken by himself and his co-worker to compute this census of anophiline mosquitoes, but from the fact that one of the partners to this research (Dr. E. W. F.) has only been attached to the staff of the Bureau of Microbiology for a comparatively short time, and that both of the members had numerous other important duties to perform, the steps taken to compile this census cannot have been very extensive.

I was, however, very interested to notice that among the localities where specimens were obtained was the Hawkesbury Bridge, for it was in close proximity to this region, viz., in the swampy district around Gosford, that my patient lived, and it was in this district that he contracted his attack of malaria.

That the research, so far, has not been a very complete one is evidenced by a statement made in the body of the official note.

Referring to the fact that at Overland Corner, on the Murray River, not far from Mildura, in South Australia, considerable numbers of *Nyssorhynchi* were found, the conclusion is come to that "it is highly important, therefore, in the western parts of this State, especially along the Darling system of rivers, an effort should be made to ascertain the relative prevalence of the mosquitoes."

Dr. Cleland next appeals to the testimony afforded by the history of the disease to substantiate his contention that there is but slender likelihood of the disease becoming endemic in N.S.W., but while doing so admits that "in the past malarial fever may have been epidemic in certain parts of New South Wales," and in support of this statement quotes reports by Dr. F. Storie Dixson and Mr. A. M. Lee, of the South Australian Museum.

In the face of such an admission it is difficult to understand that he should express the view that there is but little likelihood of the disease becoming endemic in N.S.W.

A reference to the history of malaria in other countries unfortunately does not substantiate Dr. Cleland's views on this matter.

It was only in the early sixties of last century that malaria became endemic in Mauritius, and it was thought at the time that the epidemic was due to the opening up of new ground, but it has since been pointed out by Sir Ronald Ross that it was the introduction into the island of a malaria-carrying mosquito (*Pyretophorus costalis*) that caused it to become an epidemic centre of malaria.

Dr. Cleland next proceeds to mention the fact that cases of malarial fever from time to time are received into the Sydney Hospitals, and that the patients may have mixed with the general population throughout the State, and yet no malarial centre has so far been established.

Having been attached to the honorary staff of the Sydney Hospital for a period of 23 years, I can substantiate the correctness of the statement that cases of malaria do find their way (and not infrequently too) into the Sydney hospitals, but I would also like to point out that such cases almost invariably belong to the seafaring class, and do not settle afterwards in our midst, but on restoration to health return to their previous occupation.

Unfortunately such is not the case with those soldiers who have returned from New Guinea and the Solomon Islands infected with malarial parasites, for they on the contrary have come to settle once more in our midst—a situation being thus created which I feel sure has never been before experienced in the history of New South Wales.

Moreover, that the majority of these returned soldiers have been infected with the aestivo-autumnal parasite does not lessen the danger, for as we all know, that parasite gives rise to the most malignant form of malaria, and, as Dr. Cleland admits, "the gametes in such cases are very hard finally to eliminate from the individual."

I would like, Sir, before concluding, to refer once more to the case of malaria reported by me in the columns of the Journal.

Dr. Cleland, in his official note, states that "the case is one of great importance provided the history given by the patient is one on which complete reliance can be placed."

Surely, nothing could be more definite than the history supplied by the patient as to his never having been in any parts of the world in which malaria is endemic, but if his word be doubtful further examination of the case and more careful enquiry can be made by the health authorities, as the patient is still alive, and has, I believe, returned once more to his home at Gosford.

In reporting this case, which I believe to be a genuine one of tertian malaria of local origin, my object was to call the attention of the profession and of the health authorities to the matter, with the view to the possible detection by the former of further cases, and of inducing the health authorities to take such steps as to render it impossible for malaria to gain a footing in New South Wales.

The report of a case, reasonably regarded as of local origin, the fact that the malaria-carrying mosquito, *Nyssorhynchus annulipes*, is widely (even if sparsely) distributed throughout the State, and the recent introduction into our midst of a considerable number of malaria-infected human beings who purpose residing here, are surely of sufficient importance to warrant our health authorities in taking the steps necessary to deal effectively with the mosquito problem.

Yours, etc.,

233 Macquarie Street,

SYDNEY JAMIESON.

March 5, 1915.

### Personal.

The death of Dr. M. Matheson, of Waverley, New South Wales, took place on March 29, 1915, at his residence. We understand that Dr. Matheson has been in failing health for some little time. He graduated in 1876 in Canada. He leaves a widow, two sons, and two daughters.

Dr. and Mrs. W. J. Gething, of Port Adelaide, have left for a visit of two months duration to Singapore.

Dr. A. N. Houghton, of Auckland, has left New Zealand on his way to England. It is announced that he purposes offering his services to the Royal Army Medical Corps.

Dr. N. J. Mackay, of Adavale, has left Queensland, and is now at 80a Chancer Street, St. Kilda, Victoria.

Dr. F. Tipping, M.B., Ch.M. has left Oodnatta, South Australia, and is now at Bairnsdale, Victoria.

Dr. E. A. Marsden has removed from Bundarra to Fairfield, New South Wales.

Dr. I. Manly Barrow has removed to Penrith, New South Wales.

Dr. Hugh Rayson has removed to Nyngan, New South Wales.

Dr. Merrifield has removed from Chatswood to Bellingen, New South Wales.

### Medical Appointments.

Dr. O. E. Bruce-Withers has been appointed to the medical staff of the St. Joseph's Hospital at Auburn, New South Wales.

Dr. Noel Franki has been appointed Resident Medical Officer at the Balmain and District Hospital, in place of Dr. Balls, resigned.

Dr. Grace F. Boelke has been appointed Medical Officer, Department of Public Instruction, New South Wales.

### Medical Appointments Vacant, etc.

For announcements of medical appointments vacant, assistants, locum tenentes sought, etc., see "Advertiser," page xlii.

Medical Journal of Australia, Assistant (part-time).  
Victorian Eye and Ear Hospital, Resident Surgeons.  
Kalgoorlie-Port Augusta Railway, Medical Officer.  
Launceston General Hospital, Assistant House Surgeon.  
Anti-Tuberculosis Dispensary, Sydney, Honorary Assistant Physician.

Mackay District Hospital, Resident Surgeon.  
Royal Military Hospital of Australia, Officer in Medical Charge.

### Books Received.

- THE TREATMENT, PREVENTION, AND CURE OF TUBERCULOSIS AND LUPUS WITH OLEUM ALLII, by William C. Minchin, M.D.; Second Edition, 1915. London: Baillière, Tindall & Cox; Crown 8vo., pp. 114, with 8 illustrations. Price, 5s. net.
- MATERIA MEDICA PHARMACY, PHARMACOLOGY AND THERAPEUTICS, by W. Hale White, M.D. (Lond.), M.D. (Dub.), (Hon.); Fourteenth Edition, 1915. London: J. & A. Churchill; Crown 8vo., pp. 712. Price, 6s. 6d. net.
- MUTER'S SHORT MANUAL OF ANALYTICAL CHEMISTRY, QUALITATIVE AND QUANTITATIVE, INORGANIC AND ORGANIC, Edited by J. Thomas, B.Sc.; Tenth Edition, 1915. London: Baillière, Tindall & Cox; Royal 8vo., pp. 237. Price, 6s. net.
- THE EXTRA PHARMACOPOEIA OF MARTINDALE AND WESTCOTT, Vol. I., revised by W. Harrison Martindale, Ph.D., F.C.S., and W. Wynn Westcott, M.B., D.P.H.; Sixteenth Edition, in two volumes, 1915. London: H. K. Lewis; Fcap. 8vo., pp. 1113. Price, 14s. net.
- THE EXTRA PHARMACOPOEIA OF MARTINDALE AND WESTCOTT, Vol. II., revised by W. Harrison Martindale, Ph.D., F.C.S., and W. Wynn Westcott, M.B., D.P.H.; Sixteenth Edition, in two volumes, 1915. London: H. K. Lewis; Fcap. 8vo., pp. 469. Price, 7s.
- QUAIN'S ELEMENTS OF ANATOMY, Eleventh Edition, Edited by Sir Edward Albert Schäfer, LL.D., Sc.D., M.D., F.R.S., Johnson Symington, M.D., F.R.S., and Thomas Hastie Bryce, M.A., M.D., in Four Volumes, Vol. IV., Part I., Osteology and Arthrology, by T. H. Bryce, 1915. London: Longmans, Green & Co.; Royal 8vo., pp. 329. Price, 12s. 6d.
- PRESCRIBERS' FORMULARY AND INDEX OF PHARMACY ADAPTED TO THE 1914 PHARMACOPOEIA, by Thomas Pugh Beddoes, M.B., B.C. (Camb.), F.R.C.S. (Eng.); Second Edition, 1915. London: Baillière, Tindall & Cox; pocket size, pp. 148. Price, 2s. 6d. net.

### Diary for the Month.

- Apr. 13.—Tas. Branch, B.M.A., Monthly and Council.  
Apr. 13.—N.S.W. Branch, B.M.A., Council.  
Apr. 14.—Melbourne Pediatric Society.  
Apr. 14.—Northern District Med. Assoc. (N.S.W.), Glen Innes.  
Apr. 15.—Vict. Branch, B.M.A., Council.  
Apr. 16.—E.S. Med. Assoc. (N.S.W.), General.  
Apr. 17.—N. Suburbs Med. Assoc. (N.S.W.), Annual Meeting.  
Apr. 20.—N.S.W. Branch, B.M.A., Executive and Finance Committee; Ethics Committee.

- Apr. 21.—W. Aust. Branch, B.M.A., Monthly.  
Apr. 21.—Vict. Branch, B.M.A., Clinical Meeting.  
Apr. 21.—W. Suburbs Med. Assoc. (N.S.W.), Annual Meeting.  
Apr. 23.—Q. Branch, B.M.A., Council.  
Apr. 27.—Vict. Branch, B.M.A., Eye and Ear Section.  
Apr. 27.—N.S.W. Branch Organization and Science Committee; Medical Politics Committee.  
Apr. 28.—Vict. Branch, B.M.A., Council.  
Apr. 29.—S. Aust. Branch, B.M.A., Monthly.  
Apr. 30.—Melbourne Hospital Clinical Society.

Covers for binding the *Medical Journal of Australia* for 1914 can be obtained on application to the Manager, B.M.A. Building, 30-34 Elizabeth Street, Sydney. The price of a cloth cover is 2s. and of half leather 3s. 6d., postage 7d.

### Important Notice.

Medical practitioners are requested not to apply for any appointment referred to in the following table, without having first communicated with the Honorary Secretary of the Branch named in the first column, or with the Medical Secretary of the British Medical Association, 429 Strand, London, W.C.

Branch.	APPOINTMENTS.
<b>QUEENSLAND.</b> (Hon. Sec. B.M.A. Building, Adelaide Street, Brisbane).	Brisbane United F.S. Institute. F.S. Lodges at Longreach. F.S. Lodges at Warwick.
<b>WESTERN AUSTRALIA.</b> (Hon. Sec. 230 St. George's Terrace, Perth).	Swan District Medical Officer. All Contract Practice Appointments in W.A.
<b>NEW SOUTH WALES.</b> (Hon. Sec. 30-34 Elizabeth Street, Sydney).	Australian Natives Association. Balmain United F.S. Dispensary. Burwood District F.S. Institute. Canterbury District F.S. Dispensary. Goulburn F.S. Association. Leichhardt and Petersham Dispensary. M.U. Oddfellows Med. Inst., Elizabeth Street, Sydney. Marrickville United Friendly Societies' Dispensary. N.S.W. Ambulance Association and Transport Brigade. N. Sydney United F.S. People's Prudential Benefit Society. Phoenix Mutual Provident Society. F.S. Lodges at Braidwood. F.S. Lodges at Casino. F.S. Lodges at Lithgow. F.S. Lodges at Mudgee. F.S. Lodges at Orange. F.S. Lodges at Parramatta, Penrith, and Auburn. F.S. Lodges at Wellington. Killingworth Colliery, Newcastle. Seaham Colliery No. 1, Newcastle. Seaham Colliery No. 2, Newcastle. West Wallsend Colliery, Wallsend.
<b>SOUTH AUSTRALIA.</b> (Hon. Sec. 3 North Terrace, Adelaide).	The F.S. Medical Assoc. Incorp., Adelaide.

### EDITORIAL NOTICES.

Manuscripts forwarded to the office of this Journal cannot under any circumstances be returned.

Original articles forwarded for publication are understood to be offered to the "Medical Journal of Australia" alone, unless the contrary be stated. All communications should be addressed to "The Editor," "Medical Journal of Australia," B.M.A. Building, 30-34 Elizabeth Street, Sydney, New South Wales.

The following periodicals are required by the Librarian of the New South Wales Branch of the British Medical Association to complete the series for binding. Members who have borrowed these journals are requested to return them as soon as possible.

Lancet, November 7, 1914.  
Lancet, November 14, 1914.